UNIVERSITY OF TORONTO - FACULTY OF DENTISTRY
DENTAL RESIDENCY PREFERENCE FORM

Deadline: November 10, 2009.

NAME: _____
Surname Given Names

Instructions
The University of Toronto Teaching Hospitals Programs are listed below. Through the interview process, you have had an opportunity to visit these institutions and meet with the review committees. Please rank your preference(s) from # 1 to # 3 by circling the appropriate number beside each institution [with # 1 being your first choice of institution for a dental residency position]. If you do not have a preference and are willing to accept a residency position at any institution, indicate your choice under "No Preference".

Institution	**Ranked Order of Preference**	**If you do not wish to rank this institution, check √ here.**
The Hospital for Sick Children	1 2 3	
Mount Sinai Hospital	1 2 3	
Sunnybrook Health Sciences Centre	1 2 3	
NO PREFERENCE	1	
NO LONGER WISH TO BE CONSIDERED	☐ If you want to cancel your application check this box.	

_____ _____
Signature Date

Print and complete this form. Return your completed form to:

The Admissions Office
Faculty of Dentistry, University of Toronto
124 Edward Street
Toronto, Ontario, Canada M5G 1G6

Phone: (416) 979-4901, ext. 4373/ Fax: (416) 979-4944/ Email: admissions@dentistry.utoronto.ca