# POSTGRADUATE PROGRAM IN ORAL MEDICINE/PATHOLOGY AND THERAPEUTICS

**CURRICULUM VITAE**

*(The current CV should be typed and accompanied by copies of all transcripts, certificates and relevant documents corresponding to all activities and issues mentioned by the applicant.)*

Please choose **one of** the following Disciplines:

**🞏 1. Oral Medicine and Pathology**

**🞏 2. Hospital Dentistry**

**🞏 3. Dentoalveolar Surgery**

Applicant’s photograph

**Surname: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**First name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Home address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_**

**Postcode\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**City and Country of permanent residence:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Τel.:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Fax: \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_**

**E-mail:\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Business address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Τel: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Nationality: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Marital status: Single: Married:**

**Place and Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Dental Education**

**University, School, Department: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of entry: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Graduation date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_**

**Grade of Degree awarded: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Grades in Courses relevant to the Discipline chosen:**

**Α. Course: \_\_\_\_\_\_\_\_\_\_\_\_\_Grade:\_\_\_\_\_\_\_\_\_\_**

**Β. Course: \_\_\_\_\_\_\_\_\_\_\_\_\_ Grade: \_\_\_\_\_\_\_\_\_\_**

**C. Course: \_\_\_\_\_\_\_\_\_\_\_\_\_ Grade: \_\_\_\_\_\_\_\_\_\_**

**D. Course: \_\_\_\_\_\_\_\_\_\_\_\_\_ Grade: \_\_\_\_\_\_\_\_\_\_**

**Ε. Course: \_\_\_\_\_\_\_\_\_\_\_\_\_ Grade: \_\_\_\_\_\_\_\_\_\_**

**Class Rank:**

**Postgraduate studies:**

**Undergraduate Studies related to Health Sciences (Medicine, Biology, Pharmaceuticals):**

*(Please fill this question in ONLY if you have chosen the Discipline of Orthodontics*)

**Attendance of congresses - Continuing education (seminars, lectures etc):**

**Professional activities:**

**Teaching experience:**

**Publications:**

**Lectures, oral and poster presentations:**

**Research experience:**

**Foreign languages certifications:** *(for foreigners the knowledge of the Greek language is required)*

**IT knowledge certification:**

**Recommendations** *(should be accompanied by recommendation letters):*

**Short presentation of the applicant’s interest in following postgraduate studies in the Discipline chosen:**

**Date: Signature:**

**The application form along with supporting .pdf files should be sent electronically at the e-mail address:** [**olgampika@dent.auth.gr**](mailto:olgampika@dent.auth.gr) **or by registered mail or personally submitted to the CENTRAL SECRETARIAT of SCHOOL OF DENTISTRY, AUTH, in the following address:**

ARISTOTLE UNIVERSITY OF THESSALONIKI

FACULTY OF HEALTH SCIENCES

SCHOOL OF DENTISTRY

CENTRAL SECRETARIAT

UNIVERSITY CAMPUS, P.C.-541 24, THESSALONIKI, GREECE

with the indication “**For the Postgraduate Program at the Oral Medicine/Pathology and Therapeutics, to the Discipline of** ……………………………………”