

**ADMISSIONS OFFICE
FACULTY OF DENTISTRY
UNIVERSITY OF TORONTO**

124 EDWARD STREET
TORONTO, ON M5G 1G6

**For Entry In 2026
APPLICATION FOR ADMISSION
DENTAL RESIDENCY PROGRAM**

APPLICATION DEADLINE – SEPTEMBER 30, 2025

NAME (CORRECT LEGAL NAME IN FULL)

Last First

E-mail Address

PERMANENT ADDRESS

Street Address

City Province/ State Postal/ Zip Code

Area Code + Telephone

MAILING ADDRESS (only complete if different from your permanent address)

Street Address

City Province/ State Postal/ Zip Code

Area Code +Telephone Expiry Date

BIOGRAPHICAL INFORMATION

Date of Birth Status in Canada Country of Citizenship

Date of Entry Into Canada First Language Gender Male
Female

ENGLISH FACILITY TEST (if applicable)

NAME OF TEST	TEST DATE	FOR TOEFL ONLY	
_____	_____	Overall Score: _____	TWE / Essay Rating: _____

Return your application form, application service fee and documents by the application deadline to:
The Admissions Office, Faculty of Dentistry, University of Toronto, 124 Edward Street, Toronto, Ontario, Canada, M5G 1G6.
Tel: (416) 864-8113/ Fax: (416) 979-4944/ Email: admissions@dentistry.utoronto.ca

SUPPLEMENTARY INFORMATION

REFERENCES (List your referees below.)

You must arrange for two letters of reference to be sent to the admissions office from those who are familiar with your academic and/or professional work. Both letters should provide information on your suitability for a dental residency position.

Name	Position/ Occupation
Name	Position/ Occupation

ACADEMIC HISTORY

List all Universities attended – including current studies and arrange for an official transcript from all schools attended to be sent to the Faculty of Dentistry directly from the issuing institution.

Years Attended	Name of Institution	Name of Degree	Degree Awarded	
			Yes	No

BIOGRAPHICAL STATEMENT

Explain your reasons for wishing to obtain a dental residency position. Describe what led to this decision, future career plans, your accomplishments and interests outside of dentistry, etc. You may also present other information that you feel should be taken into consideration in the assessment of your application. Attach the biographical statement to this application. Do not exceed two pages.

RESUME/ CURRICULUM VITAE

Attach a resume/ curriculum vitae to this application.

DECLARATION:

I certify that all statements on the application and in any material filed in support hereof, are true, correct and complete and that all material information has been disclosed. I understand that if the University finds to the contrary, my admission to, or registration in the University may be rescinded and cancelled after notice in writing at my home address as shown hereon. The name at the top of this form is the complete name, which I am legally and correctly known. I understand that if I have not previously applied to or registered at the University of Toronto this name will be officially recognized in academic records of the University, and it will not be changed there without a formal verification. I understand that if I have previously applied to or registered at the University and the name on this form is other than that by which I am known in the academic records of the University, I must complete a change of name form.

The University of Toronto shares information with all the hospital residency program directors across Canada. I understand that submitting an application form for the University of Toronto means that my name will be released to other program directors if I am selected for and accept admission into the University of Toronto Dental Residency Program.

Date Signature

*You can pay the \$350 CDN application service fee online by credit card on the [Student Services Payment page](#)) or you can mail in a money order/bank draft payable to the University of Toronto with your application.

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