

**Name** \_\_\_\_\_ **Date** \_\_\_\_\_

Last Name First Name Middle Name

**Present Address**

No. Street City State/Country Zip Code Telephone

**Home Address**

No. Street City State/Country Zip Code Telephone

**Date of Birth** \_\_\_\_\_ **Citizenship** ☐ U.S. Other \_\_\_\_\_ **Email** \_\_\_\_\_

Month Day Year

**Are you** ☐ left-handed **Spoken** \_\_\_\_\_ **Optional Information** ☐ Ms. ☐ Mr. ☐ Dr. ☐ \_\_\_\_\_

☐ right-handed **Languages** \_\_\_\_\_ ☐ She ☐ He ☐ They ☐ \_\_\_\_\_

**List below Colleges or Universities in which you have studied:**

Institution	Dates Attended	Degree	Date	Major	G.P.A.
_____	_____ to _____	_____	_____	_____	_____
_____	_____ to _____	_____	_____	_____	_____
_____	_____ to _____	_____	_____	_____	_____

**Record your completion of Educational Prerequisites:**

Science	Course Title & No.	Grade Lec/Lab	Dates Month & Year	Academic Institution
Vertebrate Anatomy	_____	_____	_____	_____
Vertebrate Physiology	_____	_____	_____	_____
Chemistry	_____	_____	_____	_____
Histology	_____	_____	_____	_____
<b>Art</b>				
General Drawing	_____	_____	_____	_____
Figure Drawing	_____	_____	_____	_____
Figure Sculpting	_____	_____	_____	_____
Color Media (medium)	_____	_____	_____	_____
<b>Other</b>				
English Composition	_____	_____	_____	_____
<b>Preferred Skills</b>				
Digital Media	_____	_____	_____	_____
CPR Certification	_____	_____	_____	_____
Dental Laboratory	_____	_____	_____	_____

**List below any Professional Certifications you have received:**

Credential Initials	Credential Title	Certifying Body	Period of Certification
_____	_____	_____	_____
_____	_____	_____	_____

**List below any Professional Organizations to which you belong:**

Organization Name	Initials	Membership Category	Period of Membership
_____	_____	_____	_____
_____	_____	_____	_____

**List below your most recent Clinical Work Experience:**

Organization Name	City/State/Country	Period of Experience
_____	_____	_____
_____	_____	_____

**Number of years of Unsupervised Clinical Work Experience:** \_\_\_\_\_ **Number of years of Supervised Clinical Work Experience:** \_\_\_\_\_

Last Name \_\_\_\_\_

First Name \_\_\_\_\_

## PORTFOLIO IDENTIFICATION

### PORTFOLIO GUIDE

Email [medart-info@jhmi.edu](mailto:medart-info@jhmi.edu) to request a link to a Hopkins OneDrive Folder (HIPAA compliant). Upload Portfolio, Applicant Profile, and any pertinent documents (Resume/CV, Grade Report/Transcript, Certifications, etc.) Do **not** email the portfolio!

- PDF Portfolio Presentations are preferred
- All images should be in focus and at a high resolution
- One project per presentation page
- Only properly identified artwork will be reviewed
- Portfolios are retained during the review process

### ARTISTIC PORTFOLIO REQUIREMENTS

- 15 to 20 samples of artwork

#### Required Art Categories:

- Figure or Portrait Drawing (5 minimum)
- Color Media (3 minimum)
- Digital Media (2 minimum; drawing, illustration, or painting)
- Figure or Portrait Sculpting (3 minimum)
- General Drawing (2 minimum)
- Additional examples may include: 3D Digital Modeling, 3D Printing, Sculpting (non-figure), Printmaking, or Multimedia presentations

Artistic Source: created from **(L)** - Life/Direct Observation or from **(P)** - Photo Reference

### CLINICAL PORTFOLIO REQUIREMENTS

NOTE: *Candidates who create dental appliances or maxillofacial prosthetics are requested to provide 10 before and after photographic examples of clinical work.* Clinical Source: **(S)** - Sole Practitioner or **(C)** - Collaborative Piece

Collect and maintain [Authorization for Release of Health Information Form](#) for each patient in the clinical portfolio (do **not** submit).

No.	Title or Assignment	Medium	Original Size (w" x h")	Date (mo/yr)	Source (L, P, S, or C)
01					
02					
03					
04					
05					
06					
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