



July 2013

Dear Student:

Thank you for your interest in the Davis Applied Technology College (DATC) Dental Assisting program. By entering this career field, you can expect to be presented with many challenges, rewards, and opportunities for personal growth which will enhance your potential for a successful career as a competent Dental Assistant.

Attached is the DATC Dental Assisting Program application. You should review the application guidelines and requirements carefully, and ensure you meet the admission requirements, that your application is fully completed, and you have enclosed the required supporting documentation. Sign and date your application and return it to the Dental Assisting program instructor in Room 1114 before the last Friday of the month. Failure to complete the form correctly or return it with the required documentation will result in your application being denied.

The Dental Assisting program has a limited amount of slots. If your application is approved but the number of applicants exceeds the number of places available, you will be granted *alternate status*. This means you will not have to re-apply and will be given first priority for admission into the program when a space becomes available. In the meantime you can begin the general course work.

You must submit a completed application before the last Friday of the month. Applications are accepted during the hours of 7:30 a.m. to 6:00 p.m., Monday through Thursday.

You will be notified of your acceptance status approximately ten days after receipt of your application.

If you have any questions concerning your application or the program, please contact me.

Sincerely,

Cathy Turnbow, CDA
DATC Dental Assisting Instructor
Tel: (801) 593-2349
E-mail: cathy.turnbow@datc.edu



DENTAL ASSISTING PROGRAM APPLICATION REQUIREMENTS

It is your responsibility to meet the following requirements, complete the application correctly and submit the necessary documentation. Failure to do so will result in your application being disqualified.

Admissions and Job Requirements

Verify you meet the Dental Assisting program admissions and job requirements which are available for review on the DATC Website (www.datc.edu/dental).

Completed Application Form

Submit the completed application including supporting documentation by the last Friday of the month.

Dental Office Observation Form

To be eligible to participate in the Dental Assisting program, you must have at least **four hours** of experience in a dental office. If you do not have the required work experience (as documented in the application form), you need to schedule a four hour observation at a dental office. Take the attached observation form to the dental office to document your experience.

References

Provide two completed reference forms from teachers, health professionals or employers that address your preparedness and strengths pertinent to employment as a Dental Assistant. These should be fully completed and placed in a sealed envelope by the referees and included with your completed application. **Reference forms completed by a family member will NOT be accepted.**

Letter of intent

Clear communication skills are an important characteristic for those working in the health care profession. Prepare a typed or neatly handwritten, grammatically correct letter of intent describing:

- Your reasons for selecting Dental Assisting as a career
- Accomplishments that have given you the greatest satisfaction
- Your plans and aspirations for the future

Disclaimer

Carefully review, check off and sign the disclaimer form.

Mandatory Documentation

The following are mandatory requirements for health care professionals working in a clinical setting. You are required to submit to and provide this information at the time of application. Failure to meet these requirements will disqualify your application.

A Physical Examination

You are required to undergo a physical examination to determine there are no physical or emotional limitations that would affect your ability to perform the duties required of a Dental Assistant. The attached physical examination form should be completed by the doctor performing the exam.

❑ Current Immunization Records

Provide a copy of your immunization record showing vaccinations for MMR, Hepatitis B and a current TB test. If you do not have an immunization record, you can request verification from your doctor's office. The verification must include the type of vaccine, the date given, an office stamp or a legible signature and title for each vaccine. **YOU MUST RECEIVE THE VACCINE(S) FOR WHICH YOU CANNOT PROVIDE PROPER DOCUMENTATION.** This information can be documented on the physical examination form.

❑ A Urine Drug Screen – Adult Students Only

You are required to submit to a urine drug test. Refer to the attached Urine Test information sheet for instructions on how to complete this requirement.

❑ A Federal Criminal Background Check – Adult Students Only

The DATC offers a convenient, fast, and easy way for applicants to obtain an online criminal background report. The cost is \$40 and results are sent directly to the DATC program instructor within approximately three working days. To complete the online application, go to www.datc.collegescreen.com

Note: Any misdemeanor or felony conviction on record may negatively impact your chances of being accepted into the program, being placed on an externship site, obtaining the CDA credential and obtaining employment in a healthcare setting. If you have any questions or concerns, you can discuss these with the program instructor for further guidance.



DENTAL ASSISTING PROGRAM APPLICATION

Student Name: _____
Last First Middle Initial

Address: _____
Number and Street

City State Zip

Personal Information: _____
Social Security Number Date of birth DATC ID Number

Phone Number: _____
Home Work Cell

Email Address: _____

Emergency Contact : _____
Name Relationship Phone

1. Education

Please provide information concerning high school, college, technical school, or other schools attended. Include any schools you have or are currently attending for health care training. College transcripts may be included in your application for consideration.

Name of School	City and State	Date of Entry	Date of Exit	Type of Diploma

2. Health Care Experience

List all health care employment experience (including any dental office experience) starting with your most recent position. This can also include voluntary or observational experience. **DO NOT** include experience that was part of your training for an educational program.

<i>Name of Employer</i>	<i>City and State</i>	<i>Full-time (months)</i>	<i>Part-Time (months)</i>	<i>Position Held</i>

3. Other Employment

<i>Name of Employer</i>	<i>Dates</i>	<i>Type of work</i>	<i>Position Held</i>

I HEREBY certify the statements in this application are true and complete to the best of my knowledge. I understand that falsifying information on this application may be grounds for dismissal from the program.

Signature: _____ Date: _____

Completed applications should be returned to:
Dental Assisting Instructor, Room 1114
Davis Applied Technology College
550 East 300 South,
Kaysville, UT 84037
Tel: (801) 593-2349



SCHOOL OF HEALTH PROFESSIONS DENTAL ASSISTING PROGRAM REFERENCE FORM

Part 1: Applicant: Complete Part 1 of this form and forward it to two identified references who should complete the remainder of the form.

Name of Applicant: _____

Tel: _____ E-mail: _____

Part 2: Reference:

The above named applicant has selected you to as a reference in support of an application to the Dental Assisting program at the Davis Applied Technology College. Your thorough and candid evaluation is appreciated. If admitted and enrolled in the program, this form will become part of the student's file and will be available to him/her should a request be made as guaranteed by the Family Educational Rights and Privacy Act of 1974 and its amendments.

Name: _____ Title: _____

Address: _____

Tel: _____ E-mail: _____

Length of time you have known the applicant: Years: _____ Months: _____

Relationship to the applicant:

Teacher Supervisor Employer Coworker Other (specify) _____

Part 3: Evaluation:

Rate the applicant in each of the following categories as it relates to their potential as a health care professional. Comments in each area are helpful.

Caring: demonstrates compassion, empathy, and a caring attitude towards others	Always <input type="checkbox"/>	Frequently <input type="checkbox"/>	Sometimes <input type="checkbox"/>	Rarely <input type="checkbox"/>	Never <input type="checkbox"/>	N/A <input type="checkbox"/>
Comments:						
Anxiety level: calm and in control during stressful, anxiety-provoking situations	Always <input type="checkbox"/>	Frequently <input type="checkbox"/>	Sometimes <input type="checkbox"/>	Rarely <input type="checkbox"/>	Never <input type="checkbox"/>	N/A <input type="checkbox"/>
Comments:						
Communication: communicates appropriately and professionally	Always <input type="checkbox"/>	Frequently <input type="checkbox"/>	Sometimes <input type="checkbox"/>	Rarely <input type="checkbox"/>	Never <input type="checkbox"/>	N/A <input type="checkbox"/>
Comments:						

<p>Maturity: shows responsibility, self-awareness, discipline and is responsive to criticism</p> <p>Comments:</p>	Always <input type="checkbox"/>	Frequently <input type="checkbox"/>	Sometimes <input type="checkbox"/>	Rarely <input type="checkbox"/>	Never <input type="checkbox"/>	N/A <input type="checkbox"/>
<p>Character: demonstrates personal integrity, accountability and responsibility</p> <p>Comments:</p>	Always <input type="checkbox"/>	Frequently <input type="checkbox"/>	Sometimes <input type="checkbox"/>	Rarely <input type="checkbox"/>	Never <input type="checkbox"/>	N/A <input type="checkbox"/>
<p>Knowledge of profession: is aware of opportunities, challenges and responsibilities</p> <p>Comments:</p>	Always <input type="checkbox"/>	Frequently <input type="checkbox"/>	Sometimes <input type="checkbox"/>	Rarely <input type="checkbox"/>	Never <input type="checkbox"/>	N/A <input type="checkbox"/>
<p>Appearance: demonstrates a professional image, is clean, neat and appropriate</p> <p>Comments:</p>	Always <input type="checkbox"/>	Frequently <input type="checkbox"/>	Sometimes <input type="checkbox"/>	Rarely <input type="checkbox"/>	Never <input type="checkbox"/>	N/A <input type="checkbox"/>
<p>Initiative: exhibits creativity and problem solving skills</p> <p>Comments:</p>	Always <input type="checkbox"/>	Frequently <input type="checkbox"/>	Sometimes <input type="checkbox"/>	Rarely <input type="checkbox"/>	Never <input type="checkbox"/>	N/A <input type="checkbox"/>
<p><u>Additional comments:</u></p>						
<p><u>Health care experience:</u> Has the applicant worked in a healthcare facility or environment in either a paid, voluntary, or observational capacity? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, please provide details)</p> <p>Job Title: _____ Dates: _____</p> <p>Name of Employer/Organization: _____</p> <p>Summary of Responsibilities: _____</p> <p>_____</p>						
<p><u>Recommendation:</u> Indicate your overall recommendation of this candidate as a future Dental Assisting student.</p> <p><input type="checkbox"/> Highly Recommended <input type="checkbox"/> Recommended <input type="checkbox"/> Not Recommended</p> <p>Signed _____ Date _____</p>						

Thank you for your assistance. Please seal the completed form in an envelope, signing on the sealed area and return it to the applicant in a timely manner. Your recommendation is part of a packet the applicant must submit to the College to be considered for a place in the Dental Assisting Program. If you have any questions, please contact the DATC Dental Assisting program instructor at: 801-593-2349.



DENTAL ASSISTING PROGRAM: DENTAL OFFICE OBSERVATION FORM

Part 1: Applicant:

Complete Part 1 of this form and take it to the dental office where you have chosen to complete your observation experience. The dental office will complete the remainder of the form and return it to the DATC.

Name of Applicant: _____

Address: _____

DOB: _____ Tel: _____

Part 2: Dental Office:

The above named applicant is preparing to submit an application to the Dental Assisting program at the Davis Applied Technology College. To be eligible for the program, students must have at least **four hours** of experience in a dental care setting. As the applicant does not have this work experience, they have chosen to observe in your dental practice. If admitted and enrolled in the program, this form will become part of the student's file and will be available to him/her should a request be made as guaranteed by the Family Educational Rights and Privacy Act of 1974 and its amendments.

Name: _____ Title: _____

Dental Office: _____

Address: _____

Tel: _____ E-mail: _____

Part 3: Evaluation:

Please verify and document the applicant's observation experience and provide your recommendation. You may write any additional comments on the reverse of this form.

Observation:

The applicant observed in this dental care setting Yes No

Dates: _____ Total hours: _____

Experiences: _____

Recommendation:

Indicate your overall recommendation of this candidate as a Dental Assisting student.

Highly Recommended Recommended Not Recommended

Signed _____ Date _____

Thank you for your assistance. Please mail the completed form to: Cathy Turnbow, Dental Assisting Program Instructor, DATC, 550 E, 300 S, Kaysville, UT 84037. Tel: 801 593-2349.



URINE DRUG TEST PROCEDURE DENTAL ASSISTING PROGRAM

You are required to obtain a drug test as part of your application into the DATC Dental Assisting Program.

You must attend an Intermountain Healthcare Work-Med Clinic. You can look up locations at www.intermountainhealthcare.org. The nearest location to the DATC is:

IHC WorkMed Clinic

2075 North University Park Blvd., 2nd Floor (the entrance is on the southwest side of the building)
Layton, UT 84041

Tel: (801) 776-4444

Hours: Monday to Friday: 8:00 a.m. – 3:00 p.m. (no appointment necessary)

For after hours screening, call (801) 543-4089

On the day of your test, bring the following three items with you:

- This document:** Hand this notice to the clerk.
 - \$30.00 Drug Screening fee:** Cash or cashier's check/money order only. No credit cards or personal checks will be accepted.
 - Valid photo I.D:** (i.e. Driver's License or Passport).
-

If your drug test reveals the presence of a non-prescribed controlled substance, it may affect your eligibility to be accepted into the program.

Test results will be sent directly to the Davis Applied Technology College.



**DAVIS APPLIED TECHNOLOGY COLLEGE
SCHOOL OF HEALTH PROFESSIONS**

The purpose of the Medical Statement is to verify that your health care provider has discussed health conditions with you that could affect your career choice or training program. Current physical exam and immunizations are a requirement of the healthcare facilities that provide clinical/externship components of your training program.

PERSONAL INFORMATION (to be completed by the student)

Last Name	First	Middle	Social Security Number	
Address			City	State Zip
				Telephone Number

PHYSICAL EXAMINATION (to be completed by the examining health care provider)

- Vision: Corrected ____ Uncorrected ____
Right 20/ ____ Left 20/ ____
- Urinalysis:
Glucose ____ Albumin ____ Micro ____
- Hearing: Corrected ____ Uncorrected ____
Right ____ Left ____
- Prescribed Medication:
Type Dosage

- Vital Signs:
Blood Pressure: _____ Pulse: _____
- Physical Limitations:
Can lift at least 50 lbs: yes ____ no ____
Able to stand for extended periods: yes ____ no ____
Latex allergy: yes ____ no ____
Other limitations: _____

Abnormalities: Yes/No	Comments
Head, ENT	_____
Eyes	_____
Skin	_____
Respiratory	_____
Cardiovascular	_____
Gastrointestinal	_____
Hernia	_____
Genitourinary	_____
Musculoskeletal	_____
Metabolic/ Endocrine	_____
Neurological	_____
Psychiatric	_____

8. Immunizations:
Contractual agreement with clinical/extern sites requires proof of immunization or titer showing immunity on all of the following:

- Hepatitis B (3 doses) 1 _____ 2 _____ 3 _____
- MMR (2 immunizations) 1 _____ 2 _____
- Tdap (Whooping cough) _____
- Varicella (Chicken pox) _____

TB skin test _____
If TB test is positive, chest x-ray _____

According to my examination, there are no physical or emotional limitations that would affect this person's ability to function as a Medical/Dental (circle one) Assistant.

Signature of Health Care Provider

Date of Examination: _____

Print Health Care Provider's Name and Title

License #: _____

Phone #: _____

Address City State Zip



DENTAL ASSISTING PROGRAM DISCLAIMER

Name: _____

Application date: _____ Student number: _____

After you have reviewed the Dental Assisting Program Admission Requirements and Application, please read the following statements carefully and check each box to state you have read, understood and acknowledge these requirements in order to apply for a place in the program.

- I confirm I meet the admission requirements and job requirements as detailed under the “Admissions and Job Requirements” on the Dental Assisting web page on the DATC website (www.datc.edu/dental).

Program Attendance

Satisfactory progress during Dental Assisting training requires regular attendance.

- Part-time and/or flexible scheduling is available but you must be enrolled in the program for a minimum of 12 hours per week.
 - During the clinical/externship portion of the program, full-day scheduling will be required.
 - Clinical externships are expected to be a minimum of 8 hour shifts, at least 4 days per week (exact scheduling to be determined and agreed with the extern site).
- I have read and understand the required program attendance requirements as stated above and confirm I will be able to commit to the prescribed hours for training and clinical externships.
- I understand that as an allied health care worker, I may be at risk of acquiring hepatitis and other infectious diseases due to work-related exposure to potentially infected bodily fluids (blood and saliva). In recognition of this risk, I understand that if I am admitted into the program, the DATC will advise me of the modes of disease transmission, methods, and procedures for minimizing transmission, and the appropriate protocol to be followed in the event of exposure to potentially infected bodily fluids.
- I understand my application may be denied based upon the results of a urine drug screening, criminal background check and physical examination.
- I am a secondary (adult) student and understand that I must have my high school diploma or equivalent prior to my participation in the clinical experience.

Signature: _____ Date: _____

Parent or Legal Guardian Signature (if minor) _____ Date: _____



DENTAL ASSISTING PROGRAM APPLICATION CHECKLIST

Student Name: _____ Student Number: _____

The application **must** include the following documentation. Your application will be disqualified if you fail to provide the required documentation during the designated application period.

- Completed Program Application
- Copy of High School Diploma or equivalent (prior to clinical course work)
- Two Reference Forms (in sealed envelope)
- Dental Office Observation (if applicable) (to be returned by the dental office)
- Letter of Intent
- Signed Disclaimer
- Completed Physical Examination Form (incl. immunization record)
- Adult Student Only** - Online Criminal Background Check (Results sent directly to program instructor)
- Adult Students Only** - Urine Drug Screening (Results sent directly to DATC program instructor)

Applications must be submitted by the last Friday of the month and are accepted during the hours of 7:30 a.m. to 6:00 p.m., Monday through Thursday.

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Tel: (801) 593-2349

DATC USE ONLY:

Date Received: _____ Received by: _____ Initials: _____