DENTAL ASSISTANT PROGRAM

Please attach this page as the coversheet to your application packet.

Name: **DOB:**

Please refer to Admissions Requirements as listed on the Dental Assistant Rack Card OR the website www.alvincollege.edu/cewd/health_care/dental_assistant.htm

Step 1	2 PLANS	DEADLINE FOR APPLICATION	CLASSES BEGIN	✓
Choose Your Plan	PART-TIME* (EVENINGS)	**JULY**	August/September – Each Year	
	FULL-TIME (DAYS)	**OCTOBER**	January - Each Year	
Step 2	**Cover Sheet** (This Page)	Attach to application Packet		
	Must be **High School Grad** or have **GED**	Copy of Diploma/Certificate with application. ***Be prepared to show original document***		
	Physical/Health Status Report	Use Form Provided in Packet		
	Healthcare Vaccinations	List Provided in Packet ***Be prepared to show original document***		
Gather together ALL information and turn completed application by deadlines	**Social Security Card**	Copy of original, ***Be prepared to show original document***		
Step 3	Meet with Program Coordinator	Review Application Packet		
	Background Check	Needs to be completed prior to DNTA orientation		
	Schedule DNTA Orientation	**Mandatory for ALL incoming Dental Assistant Students**		
	Current CPR Certification	Can be taken during first semester. MUST be a Healthcare Provider CPR course		
General Information for incoming Students	Malpractice Insurance	Purchased during courses		
	Additional Tests for State License	Completed during courses		

We are pleased to welcome you to Alvin Community College and look forward to assisting you in the starting of your career goal in dentistry. As a Registered Dental Assistant, you will have the opportunity to work in the many different specialty fields of dentistry.

Any questions should be directed to the Dental Assistant Coordinator
Leigh Davis, RDA 281-756-3820

This checklist has been prepared to help you through the application process.
It is suggested that you make a copy of your application for your records.

***If you enroll in the part-time program classes are scheduled in the evenings, with exception of the DNTA 1064 for clinical.**

8/2011

ACC
ALVIN COMMUNITY COLLEGE
DENTAL ASSISTANT PROGRAM

Dental Assistant Program

APPLICATION FOR PROGRAM ADMISSION

Please indicate which plan you are interested in enrolling for the program. **Evening** ______OR **Day** ________**Year:**_________

Note: **This application is valid only for the indicated year. A new application must be submitted each year the applicant is interested in applying. Applications are accepted year round.**

SOC SEC# ______-_____-_________ ACC Student ID_______________ Date of Birth ______________

Leave blank if you do not have one. *mm/ dd/ yyyy*

NAME__________________________, ______________________________, _________________________________

Last *First* *Middle Initial and or Maiden Name*

ADDRESS ____

Number & Street City County State Zip Code

PHONE (________) _______________________ ALTERNATE PHONE (________) _________________________

EMAIL ADDRESS ____

EMERGENCY CONTACT ____

(Name) (Relationship) (Phone #)

If you answer yes to any of the following, please contact the DNTA Program coordinator.

Y N Have you ever been convicted of a drug related felony or a felony involving moral turpitude?

Y N Have you ever been chronically or habitually intoxicated or addicted to intoxicants, drugs, or controlled substances?

Y N Have you ever been the subject of a pending prosecution for an offense that is a felony under the law of Texas?

Y N Have you ever received deferred adjudication or been arrested or convicted of a crime?

Are you physically capable of performing CPR? Y N Are you current with suggested vaccinations? Y N

Can you provide documentation of vaccinations? Y N If, no, please explain _______________________________

I understand that my potential for employment as a Dental Assistant is greatly enhanced if I am able to read speak and write English at a level to allow accurate patient data collection, patient instruction and daily interaction with the public and other dental professionals. Suggested prerequisite courses, passing scores on an appropriate assessment examination OR department approval will be required for admission to the program. Any tests or additional classes will be assessed at the personal interview. Any additional expense to administer such tests and/or classes will be the responsibility of the student. ____________(Please initial)

It is the student's responsibility to:

Return the application packet to the Dental Assistant Program Coordinator H115,the personnel of the CE/Workforce Development Office located in H103, or by mail. Include a copy of the checklist completed, and all required documentation enclosed for review and approval by the chosen plans due date. **Please do not fax or email due to privacy and the security of application.**

3110 MUSTANG ROAD, ALVIN, TX 77511-4898 **Phone: 281-756-3820**

Incomplete applications will not be considered.

I HEREBY UNDERSTAND THE APPLICATION PROCESS AND STATE THAT ALL INFORMATION PROVIDED ABOVE IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

____

(Signature) (Date)

STUDENTS WITH DISABILITIES

This college adheres to all applicable federal, state, and local laws, regulations, and guidelines with respect to providing reasonable accommodations as required affording equal educational opportunity. ACC provides reasonable accommodations for qualified individuals who are students with disabilities. It is the student's responsibility to contact the Counseling Center in a timely manner to arrange for appropriate accommodations. Once the disability is identified, please notify your Instructor for additional modifications.

FOR OFFICE USE ONLY **REVIEWED BY:** ____ **DATE** ____________________

☐ Completed ☐ Not completed Student Advised of Status ~ Date________________________ ☐ by email ☐ by mail

ALVIN COMMUNITY COLLEGE DEPARTMENT OF CONTINUING EDUCATION
3110 MUSTANG ROAD ALVIN, TX 77511-4898
Phone: 281-756-3787 * Fax: 281-756-3952 * Email: ce@alvincollege.edu

IMMUNIZATION RECORD

Health Program	**Dental Assistant H116**

Student Name: ____ Date of Birth ________________________

Checklist:

All applicants must provide a copy of written documentation from a physician or public health authority for:

____ **Varicella** (Chicken pox) - Proof of either (a) a physician-documented history of the disease, or (b) documentation of two varicella immunizations, or (c) a serum titer confirming immunity. ** ***Note***: The varicella injection series is a four-week process. If first dose of varicella was received prior to thirteen years of age only one dose necessary. Proof of date of birth must be included.

____ **Hepatitis B -** Proof of either: (a) a complete three-injection series of hepatitis B vaccinations, or (b) a serum titer confirming immunity. ** ***Note***: The hepatitis B injection series is a 4-6 month process. There must be a minimum of four weeks between the 1st and 2nd immunization, minimum of eight weeks between the 2nd and 3rd immunization, and a minimum of sixteen weeks between the 1st and 3rd immunization.

____ **Measles -** Proof of either: (a) two doses of measles vaccine on or after first birthday, or (b) a physician-documented history of disease, or (c) a serum titer confirming immunity. ** ***Note***: Students born before Jan. 1, 1957 are exempt from the measles requirement. There must be at least four weeks between the first and second measles vaccination.

____ **Mumps -** Proof of either: (a) one dose of mumps vaccination on or after first birthday, or (b) a physician-documented history of disease, or (c) a serum titer confirming immunity. ** ***Note***: Students born before Jan. 1, 1957 are exempt from the mumps requirement.

____ **Rubella -** Proof of either: (a) one dose of mumps vaccination on or after first birthday, or (b) a physician-documented history of disease, or (c) a serum titer confirming immunity. ** ***Note***: All students are required to show proof of rubella.

***Combined MMR vaccine is vaccine of choice if recipients are likely to be susceptible. ***

____ **Tetanus** - Proof of tetanus vaccination within the last 10 years; at time of application.

____ **Tuberculosis** (TB) - Proof of TB test (PPd skin test or chest x-ray) with a negative reading.
(Test may not be more than 180 days old on the first day of class.)

Important: Documentation of immunizations ARE required at the time of application. Program applications may not be accepted without completed immunization documentation. Vaccines administered on or after September 1, 1991 must include the mm/dd/yy each vaccine was given. *Physician-documented history of disease and serum titers must be the date of diagnosis or test collection not when formed signed by health care provider.*

The Texas Dept. of Health requires immunizations for students enrolled in health related courses.

Date (mm/dd/yr)	**Vaccine**	**Validation Signature/Stamp**
	MMR (measles, mumps, rubella)	
	T/D (Tetanus/Diphtheria)	
	Hepatitis B (3 doses)	
	Varicella (Chickenpox) /Date of Disease	
	Tuberculosis (TB) Skin or X-ray Negative reading	

I, ____ hereby state that all information provided above is true and
(Print Student/Patient Name)

accurate to the best of my knowledge.

____
(Signature of Student) (Date)

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PHYSICAL EXAM FORM

Health Program	**Dental Assistant**

Student/Patient Name:____ **Date of Birth:**________________________

NOTE: While confidentiality of this information will be maintained, full health information is necessary for the student's protection as well as that of others.

Section to be completed by Student

1. Medical History:

Please identify any of the following for which you have received medical treatment within the past five years:

	Rheumatic fever		Menstrual disorders		Joint disease
	Back injuries		Epilepsy		Cardiovascular disease
	Hay fever		Diabetes		Sinusitis
	Frequent colds		Tuberculosis		Thyroid disease
	Anemia		Asthma		Ulcer/colitis
	Hypertension		Frequent headache		Other (please describe)

Please list (with dates if possible):

1.	Chronic illnesses
2.	Current medications
3.	Physical limitations
4.	Currently pregnant*

**If yes, must provide Physician's release*

Section to be completed by Primary Care Provider

2. Physical Examination:

The Primary Care Provider is requested to make a complete physical examination of the student and note any deviations from normal.

Height	Weight	Pulse	B/P

Condition of:

SYSTEM	NORMAL	ABNORMAL	COMMENTS	SYSTEM	NORMAL	ABNORMAL	COMMENTS
skin				heart			
eyes				abdomen			
ENT				reflexes			
neck				musculoskeletal			
lungs							

Describe any abnormal findings: ____
____

I examined ____ on this date and found him/her to be in __________________ health.
(Student /Patient Name)

Primary Care Provider's Name (Please Print)	**Primary Care Provider's Signature (Please sign)**
Office Address (Street)	Telephone
City State Zip	Date