

CLASS APPLICATION

COURSE TITLE: _____

COURSE DATE: _____

LEGAL NAME: _____

AMOUNT ENCLOSED: _____

HOME ADDRESS: _____
Street City Zip Code

PHONE: (Home) _____ (Cell) _____

Soc Sec No. Last 4 Digits - _____

HIGH SCHOOL GRAD: _____ Yes _____ No

DENTIST'S NAME: _____

OFFICE PHONE: _____ FAX: _____

OFFICE ADDRESS: _____
Street City Zip Code

PREVIOUS EXPERIENCE: _____

EMPLOYING DENTIST PLEASE COMPLETE THE FOLLOWING:

This employee has been working for me for ____ Months ____ Years in the dental office. I agree to provide clinical experience under my direct in room supervision. I agree to evaluate the applicants' performances. Once the course is completed the assistant may not continue these duties until the required boards are passed and the state certificate is received.

DENTIST'S SIGNATURE: _____

DATE: _____