Thank you for your interest in Vernon College’s 2014-15 Dental Assisting program. Please follow the check list and turn in completed packet to the Continuing Education Department. Completed packets must be turned in by 5:00 pm on August 6, 2014. Informational meeting will be held on Thursday, August 7, 2014 at 6:00 pm in the Dental Lab, Room 2312. Class selections will be made by August 13, 2014. For those selected, payment for FALL Semester is due by 12:00 pm on Friday, August 29, 2014.

CHECK LIST: (Please check each item as it is completed and/or attached)
1. Read Dental Assisting flier and course requirements

2. Update shot records with all current vaccinations (attach to application):
   - Tetanus (Td) within last 10 years
   - 2 doses MMR
   - Hepatitis B Series (series of 3 shots must be completed by Jan. 5, 2015)
   - Varicella (proof of 2 vaccinations or note indicating had chicken pox as a child)

3. Current CPR Card (attach copy of card)

4. Dental exam/x-rays within past 12 months (Complete Dental History form)

5. Physical Exam (Dr. to complete Dental Assisting Student Physical Examination form)

6. Complete Authorization for Criminal Background Search

7. Complete Policies Agreement & Waiver of Release from Liability form

8. Complete Confidentiality Agreement

9. Write a short essay on “Why I want to be a Dental Assistant” and “What first interested me in the program”

10. Complete attached questionnaire

11. Attach copy of Driver’s License or State Issued picture ID

12. Take reading portion of “Accuplacer” and attach scores

If you have any questions about this packet or the requirements, please contact:

Vernon College
Continuing Education
4105 Maplewood
Wichita Falls TX 76308
940 696 8752 ext 3213

Summer Office Hours:
M-Th 8:00 am-5:30 pm; Closed Friday
DENTAL ASSISTING 2014 - 15

The Dental Assisting Program is designed to prepare students for entry level positions in one of the fastest growing health care positions – Dental Assisting. The dental assisting program will cover key areas and topics exposing the student to both classroom and laboratory hands-on instruction. After successfully completing the course students will be ready to take the State of Texas “Registered Dental Assistant (RDT)” exams.

Dental Assistants work under the direction of other health care professionals, usually in dental offices, hospitals, health clinics and other health care settings. Under direct supervision the dental assistants are responsible for assisting dentists and dental hygienists with patient care as well as provide certain administrative support to the office.

Admission Requirements:

- Must attend and complete all 6 classes
- Minimum age 18 years of age
- Visual acuity with/without corrective lenses.
- Physical ability to stand for prolonged periods of time when needed, and move from room to room or maneuver in limited spaces.
- Ability to communicate effectively in verbal and written form. Ability to speak clearly and succinctly when explaining treatment procedures, providing oral hygiene instructions, and giving general instructions to patients. Ability to write legibly and correctly in patient charts for legal documentation.
- Must take Accuplacer (Reading section)
- Manual dexterity to use sterile techniques, prepare and transfer dental materials, and transfer instruments
- Ability to function safely under stressful conditions, adapting to ever-changing clinical situations involving patient care.
- Physical and Dental Examinations
- Proof of Current CPR certification
- A form must be signed at the first class meeting regarding confidentiality, release of information, and a general release from liability
- No criminal convictions or on probation
- Must have current vaccinations (MMR, TD, Varicella, Hepatitis B)

<table>
<thead>
<tr>
<th>Title</th>
<th>Dates</th>
<th>Time</th>
<th>Location</th>
<th>Tuition</th>
<th>Book Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>A&amp;P for Medical/Dental Assist</td>
<td>M 9/08/14-12/15</td>
<td>6 PM- 9:30 PM</td>
<td>CCC 716</td>
<td>$365.00</td>
<td>$174.50 + tax = $188.90</td>
</tr>
<tr>
<td>Dental Science</td>
<td>Tu 9/09/14-1/15</td>
<td>6 PM- 9 PM</td>
<td>CCC 2312</td>
<td>$297.00</td>
<td>Approx. $125</td>
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<tr>
<td>Dental Materials</td>
<td>Th 9/11/14-2/12/15</td>
<td>6 PM- 9:30 PM</td>
<td>CCC 2312</td>
<td>$767.00</td>
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<tr>
<td>Chairside Assisting</td>
<td>Tu 1/13/15-5/26/15</td>
<td>6 PM- 9:30 PM</td>
<td>CCC 2312</td>
<td>$393.00</td>
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<tr>
<td>Dental Radiology</td>
<td>Th 2/19/15-5/21/15</td>
<td>6 PM- 9:45 PM</td>
<td>CCC 2312</td>
<td>$625.00</td>
<td>N/A</td>
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<tr>
<td>Clinical-Dental Assisting</td>
<td>M 3/02/15-5/18/15</td>
<td>6 PM- 7 PM</td>
<td>CCC 2312</td>
<td>$181.00</td>
<td>None</td>
</tr>
</tbody>
</table>

Please note there are minimum and maximum class sizes. For additional information, please call (940) 689-3713 or contact our Continuing Education office at the Century City Campus. Our email address is ce@vernoncollege.edu.
Students enrolled in health-related courses must have all the following vaccinations before they enroll in health-related higher education courses which will involve direct patient contact with potential exposure to blood or bodily fluids in educational, medical, or dental care facilities.

1. **Tetanus-diphtheria.** One dose of a tetanus-diphtheria toxoid (Td) is required within the last ten years. The booster dose may be in the form of a tetanus-diphtheria-pertussis containing vaccine (Tdap).

2. **Measles, Mumps, and Rubella Vaccines.**
   - (A) Students born on or after January 1, 1957, must show, prior to patient contact, acceptable evidence of vaccination of two doses of a measles-containing vaccine administered since January 1, 1968 (preferably MMR vaccine).
   - (B) Students born on or after January 1, 1957, must show, prior to patient contact, acceptable evidence of vaccination of one dose of a mumps vaccine.
   - (C) Students must show, prior to patient contact, acceptable evidence of one dose of rubella vaccine.

3. **Hepatitis B Vaccine.** Students are required to receive a complete series of hepatitis B vaccine prior to the start of direct patient care or show serologic confirmation of immunity to hepatitis B virus.

4. **Varicella Vaccine.** Students are required to have received one dose of varicella (chickenpox) vaccine on or after the student's first birthday or, if the first dose was administered on or after the student's thirteenth birthday, two doses of varicella (chickenpox) vaccine are required.

Students, who claim to have had the complete series of a required vaccination, but have not properly documented them, cannot participate in coursework activities involving the contact described in subsections (a) and/or (d) of this section until such time as proper documentation has been submitted and accepted.

The immunization requirements in subsections (b) and (d) of this section are not applicable to individuals who can properly demonstrate proof of serological confirmation of immunity. Vaccines for which this may be potentially demonstrated, and acceptable methods for demonstration, are found in §97.65 of this title (relating to Exceptions to Immunization Requirements (Verification of Immunity/History of Illness)). Such a student cannot participate in coursework activities involving the contact described in subsection (a) of this section until such time as proper documentation has been submitted and accepted.

**Exclusions – Medical, Religious, Military:** Persons submitting a signed affidavit from a licensed physician stating immunizations would be injurious to person’s health (exclusion valid for one year); or from parents or legal guardians (if person is a minor) stating immunizations would conflict with the tenets of a recognized church or religious denomination of which the person is a member (exclusion not valid during times of emergency or outbreak); or persons who document to Vernon College they are currently serving on active duty with the armed forces of the United States are exempt from this requirement.

**Waiver – Pregnancy:** The following immunizations are required by law according to Section 2.09 of the Texas Education Code Revised effective May 16, 1999 for all students enrolled in higher education courses involved in direct patient care contact. Requirements for varicella, measles, rubella, and mumps vaccines are waived during pregnancy. Pregnancy is not a medical contraindication for administration of Tetanus/diphtheria toxoid, but it is best to delay until the second trimester. A student is required to provide a written note from physician stating they are not able to receive these vaccinations due to pregnancy. The student should also provide written documentation from their physician of any physical limitation they have for the duration of their enrollment in the course.
Dental Assisting

Job Duties and Salary

Dental assistants perform a number of duties in a dentist's office. Some of their tasks may be clerical. Dental assistants with office duties schedule appointments, keep records, receive payments from patients, and order supplies. When patients come to the office, dental assistants locate their medical records for the dentist's use.

Dental assistants prepare patients for the dentist's examination. In addition, they perform chair-side duties, such as handing the dentist the proper materials and tools. They operate the suction hose that keeps the patient's mouth dry so the dentist can work on it. Dental assistants often operate X-ray machines. Sometimes dental assistants make an impression of a patient's mouth or teeth. They may also sterilize instruments, develop X-rays, and mix compounds for cleaning or filling teeth.

Most dental assistants work in private offices for one or more dentists. Other assistants work in public health departments, clinics, hospitals, and dental schools.

The average pay for Dental Assistants in Wichita Falls is $13.65/hour, making their annual salary $28,080 yearly.

Criminal Background

Background checks will be done on all students enrolling into the dental assisting program. Vernon College Continuing Education will take all arrests into consideration for clinical placement. Students will be counseled on convictions that may jeopardize their ability to complete the program and become an RDT. Please go to the following Texas State Board of Dental Examiners link http://www.tsbde.state.tx.us/index.php?option=com_content&task=view&id=154&Itemid=144 for additional criminal background information.
Dental History

Last Name __________________________________________ First Name __________________________________________ □ Dr. □ Mr. □ Mrs. □ Ms.
Address ..................................................................................................................................................
City __________________________________________ State __________ Zip __________

1. Date of last dental visit? _____/_____/_______ Date of last dental x-rays? _____/_____/_______

2. Reason for last visit? __________________________________________________________________________

3. Do you have any concerns about previous dental care or this dental visit? __________________________________________________________________________

4. Do your gums bleed? (circle) Yes No

5. Are your teeth loose? (circle) Yes No

6. Have you ever been told you have gum disease? (circle) Yes No

7. Have you ever been told you have bad breath? (circle) Yes No

8. Are your teeth sensitive to? (circle all that apply) Sweets Cold Heat Pressure

9. Have you ever had any pain in your jaw joints (clicking, popping)? (circle) Yes No

10. Are you happy with your smile? (circle) Yes No

   If no, please explain: _________________________________________________________________________

11. What would you change about the present condition of your mouth? _________________________________________________________________________

   • • •

I understand the need for these questions to be answered truthfully. To the best of my knowledge, the answers I have given are accurate. I also understand it is very important to report any changes or updates in my medical status. I give permission to obtain from my physician any additional information regarding my medical history needed to provide me with the best treatment possible.

Patient Signature ____________________________ Date __________

If you have completed this form for another person, please print your name and sign below along with your relationship to patient.

Print ______________________________________ Relationship ____________________________

Signature ___________________________________ Date __________

Health History Update: On a regular basis we will be asking about any changes in your medical history.

<table>
<thead>
<tr>
<th>Date</th>
<th>Changes/Comments</th>
<th>Signature of Patient and Dentist</th>
</tr>
</thead>
<tbody>
<tr>
<td><em><strong><strong>/</strong></strong></em>/_______</td>
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</tr>
</tbody>
</table>
Vernon College
2014-15 Dental Assisting Student Physical Examination

1. Name_______________________________________ Date:________________________
2. Address_______________________________________ Telephone:_____________________
3. Age_____ Height_____ Weight_____ Temperature_____ B/P_____ Allergies_________
4. Past History: Illnesses, operations and injuries (complete with dates)
________________________________________________
5. Indicate medications presently being taken that are prescribed by a physician:
________________________________________________
6. Indicate medications presently being taken that are not prescribed by a physician:
________________________________________________
8. Ears: Condition: R___________ L___________ Hearing: R___________ L___________
9. Nose: ____________________________ Sinuses: ____________________________
10. Teeth: ____________________________ Tonsils: ____________________________
11. Thyroid: ____________________________ Skin: ____________________________
12. Abdomen: ____________________________ Hernia__________________________
13. Heart: ____________________________ Lungs: ____________________________
14. Feet: R___________ L___________ Varicose Veins: ____________________________
15. Posture: ____________________________ Spinal Curvature__________________________ Reflexes__________________________
16. Defects found: ____________________________
17. Corrections made or recommended: ____________________________
18. In your opinion, is this individual psychologically and physically capable of performing the
direct client care required in dental assisting education? ( ) NO ( ) YES  If not, why?
________________________________________________
(over)
In your opinion, is this individual free of any communicable disease that would be detrimental to the patient while performing direct patient care? ____________________________________________
If no, explain________________________________________________________________________

___________________________________ Please Print Name:_______________________________
Licensed Health Care Provider’s Signature
Address:________________________________________
Phone Number:__________________________________
Authorization for Criminal Background Search

Vernon College reserves the right to conduct a criminal background search of all applicants considered for employment, students participating in work programs, and students enrolled in certain programs of study.

The following information is required to proceed with the application process. By signing, you give Vernon College permission to have the Texas Department of Public Safety Crime Records Service conduct the search, and report all findings to Vernon College.

I give permission for a Criminal Background Search to be conducted and release the findings of the criminal background search to the health care agencies affiliated with the dental assisting program at Vernon College in order for me to provide patient care in those clinical facilities as a part of the dental assisting curriculum.

This search and the findings are strictly confidential and will not be shared with any other entity.

_____________________________________  _____________________  
Full Name (please print)            Maiden Name (if any)

_____________________________________  _____________________
Other Name You Have Gone By (if any)    Date of Birth

_____________________________________  _____________________
Social Security Number             Driver’s License Number

_____________________________________  _____________________
Signature                               Date
Policies Agreement and Waiver of Release from Liability

I, ____________________, hereby affirm, by my signature below, that I attest to the following:

1. I have received a copy of, have read, and do understand the Dental Assisting course requirements, rules and policies. I agree to abide by all the provision therein. I understand that failure to comply will be grounds for dismissal.

2. I fully understand that due to the nature of the training that I shall receive, there exists the possibility of injury or infectious exposure to me, or injury or infectious exposure to others. I acknowledge and accept the fact.

3. I have been provided information from the Texas Department of State Health Services regarding Tuberculosis, have read and do understand it, and agree to follow the Tuberculosis procedures.

4. I have been provided information from the Texas Department of State Health Services regarding Universal Blood and Body Fluid Precautions for the prevention of HIV transmission in health care settings, have read and do understand it, and agree to follow the procedures.

5. I hereby release and agree to hold harmless Vernon College, and the provider sites facilities including but not limited to their trustees, administrators, coordinators, instructors, faculty, staff, and clients/patients/fellow students from any and all liability regarding aspects of dental assisting training.

6. This release shall extend to all locations considered part of the training.

7. I certify that I am 18 years of age or greater, and that I am legally competent or have a legal guardian that will verify my understanding.

Date        Student/Legal Guardian signature

05.22.14
Confidentiality Agreement

As a Dental Assisting student, I understand that during training I will come into contact with patients, and may have access to personal information regarding their names, health conditions, diagnoses and treatments, and information regarding the staff and policies of the clinical facility.

I hereby agree and affirm, by my signature below, that:

1. I will respect the confidential nature of all records, information regarding patients, and the rules and policies of clinical site(s); and
2. I will keep all such information STRICTLY CONFIDENTIAL; and
3. I will not discuss nor reveal any information in any way to any person; and
4. I will not violate the state and federal Right to Privacy Act(s); and
5. I will conform to all Policies, Rules, and Regulations of Vernon College, the Dental Assisting program, and the clinical site(s).

I understand that any violation of this Confidentiality Agreement may subject me to prosecution and can result in immediate dismissal from the course, with no refund.

I, _____________________________________________________________, swear and affirm (Print Full Name of Student) that I have read the above and, by my signature below, do hereby agree to abide by all terms stated.

________________________________________    ____________________________________________________
Date                                      Signature of Applicant

05.22.14
Dental Assisting Questionnaire

(Please complete the following questionnaire. The more information we have on you the easier the selection process is for the program. If you need extra paper please feel free to add or write on the back of this sheet.)

Applicant Name: _________________________ Date: _______________

Is this your first time to apply for the Dental Assisting program? Yes  No
If No, when did you apply before? ________________________________

Previous College or Technical Training? Yes  No
If Yes, what kind of training/college and did you complete the training?
_____________________________________________________________
_____________________________________________________________

If No, please explain (ie, just graduated from high school, stayed at home with children, etc.)
_____________________________________________________________
_____________________________________________________________

Are you currently working? Yes  No
If yes, Current Employer: _______________________________________
If no, Why? __________________________________________________

Do you have any previous Dental Assisting Training/Experience: Yes No
If yes, _______________________________________________________

Please describe your support network. Who is your biggest champion?
What arrangements have you already made to make it possible for you to go to school? (daycare, work, tuition, etc.)
_____________________________________________________________
_____________________________________________________________
_____________________________________________________________
_____________________________________________________________