



Expanded Function Dental Assistant Application

Read thoroughly, initial each page and sign and date as indicated. Include attachments as indicated. This enrollment agreement is considered a contract between the student and Idaho Center for Emergency Medical Training. A fully signed copy will be provided to the student when the application has been accepted and initial fees are paid.

Course Starting Date : Month _____ Year _____	Date of Application :
---	-----------------------

Name (Last, First, MI) :	E-Mail :
--------------------------	----------

Address :

City, State, ZIP :	Date of Birth (MM/DD/YY) :
--------------------	----------------------------

Phone (Home, Cell, Work) :	Social Security Number :
----------------------------	--------------------------

Emergency Contact :		
Name	Phone	Relationship

If you are receiving funding from an employer or government agency, please provide program information. NOTE : Agencies may require proof of student progress to provide funding.	Agency :	
	Contact Name :	Phone :

Have you ever been convicted of a felony or misdemeanor? If yes, please briefly explain.
--

What are your career goals for this program?
--

How did you hear about our program?

A licenced medical doctor (MD or DO) must verify that you are able to perform the requirements of employment as an expanded function dental assistant. You must include official documentation of immunization records.

Physician : The named applicant is applying for enrollment in our Expanded Function Dental Assistant program. Please verify that the applicant is able to perform the listed duties safely and has the listed immunizations.

Required Duties

	Full range of motion, manual and finger dexterity.
	High degree of hand-eye coordination.
	Visual acuity and adequate special perception.
	Communicate effectively with others orally and in writing.
	Gross and fine motor skills sufficient to lift, position and operate dental equipment.
	Perform work activities involving combinations of walking, kneeling, bending, pushing, pulling, lifting, carrying, and standing.
	Perform work activities requiring grip strength
	Intact proprioception (ability to sense pressure/force)

Immunization Status

Please submit official documentation

(Ex. Childhood immunization records, public health immunization records)

If you do not have an official copy of these records, please submit proof of titer test.

Titer tests can be obtained via Southwest District Health: 455-5345

1. MMR Dose #1 & 2
2. Hepatitis Doses #1, 2 & 3 (or declination form)
3. TB skin test (record result in millimeters) *** Must be current within 1 year from clinical start date.
4. Chicken Pox (titer test available)

In my professional opinion, this applicant can perform the above listed duties. I also attest that the applicant has received or appropriately declined all listed immunizations and can provide documentation and/or titers to support these immunization dates.

Physician Signature

Program Costs & Payment Options

Tuition : \$11,000

-Tuition includes price of the course, course texts, laboratory supplies, clinical protective equipment, scrubs and physical.

Payment Options :

_____ I will be paying a \$100 application fee with application, \$2000 within seven days of acceptance and the remaining balance of \$7900 on or before the class start date for a discount of \$1100.

_____ I will be paying a \$100 application fee with application, \$2000 within seven days of acceptance and the remaining \$9000 over five consecutive payments of \$1800 in weeks 3-15.

*** Failure to make a scheduled payment may result in course suspension or denial of course completion certificate.

Attached is my check, cashier's check, or money order for \$_____.

Please charge \$_____ to my credit card.

VISA

MasterCard

Amex

Discover

Card Number : _____ CVC Code : _____

Expiration Date (MM/YY) : _____

Cardholder Name (print) : _____

Cardholder Signature : _____

I authorize *Idaho Center of Emergency Medical Training* to photograph me and acknowledge that all photographs become the property of *Idaho Center of Emergency Medical Training*. I give my permission for my likeness to be used in promotional materials and electronic media.

Applicant Signature

Health Insurance Coverage

Students are responsible for their own medical expenses during their training, including expenses due to illness, accident, or injury occurring while completing laboratory exercises and clinical practice. Idaho Center of Emergency Medical Training requires that all students enrolled in career training programs possess medical insurance during the entire term for which they are enrolled. If you do not have health insurance, please contact a local health insurance provider.

Required Documents

Application will not be complete until all documents are received by Program Director.

_____ Copy of Healthcare Provider CPR Card	_____ Copy of Driver's License
_____ Proof of High School Graduation or GED	_____ Completed Physical Form
_____ Copy of Health Insurance Card	_____ Official Immunization Record
_____ Verification of Job Shadowing Form	_____ Personal CV (Curriculum Vitae)
_____ Personal Statement	

Refund Policy

- Applicants/students may cancel their enrollment within 72 hours after midnight of the day in which the completed enrollment is signed and receive a full refund of all money paid to the school.
- The applicant/student will receive a minimum of seven days in which to cancel their enrollment agreement and receive a full refund less a \$100 application fee. If student has already been accepted and submitted a \$2000 deposit, \$50 of this deposit will be retained in addition to the application fee.
- For a student who wishes to withdraw after the first day of class, the following refunds apply:
 - One half (50%) of tuition will be refunded for withdrawal during the first quarter.
 - One fourth (25%) of tuition will be refunded if the withdrawal is received after the first quarter but before the first half of the program is completed.
 - No refund will be made to the student after half of the course is completed.
- Students who are unable to complete the program due to circumstances beyond their control, such as serious illness, accident or death in the family may request in writing a leave of absence. Students may join the next scheduled class or may request consideration of a tuition adjustment.
- Any monies due to the student shall be refunded within 60 days from the termination date. The termination date is defined as the last day the student was in attendance

Program Details

- The Expanded Function Dental Assistant program is approximately 28 weeks long with an additional 7 weeks estimated for completion of externship hours.
- Didactic course lectures are to be held twice weekly in four hour blocks. Lectures will be held either Mon/Wed or Tues/Thurs (depending on course designation) from 6-10pm. Lectures will be held at ICEMT at 1018 W. Sanetta St. during weeks 1 through 28.
- Laboratory hours will be held on Fridays at Christensen Dental at 4111 Clocktower Ave during weeks 4 through 28. A laboratory block of either 8am-12pm or 1pm-5pm will be assigned by week 2. Some Saturday laboratory hours may be available or required.
- Observation and externship hours will begin in week 4 of the program. Students will be assigned to a clinical rotation in week 2. Each clinical rotation will be for a total of sixteen (16) hours per week—to be divided into either 4,6, or 8 hour sessions depending on assignment. Specific requests may be made by students for consideration up to the end of week 1.
- Following completion of didactic course work, students will increase observation/externship hours to a minimum of twenty (20) hours per week. Students will complete observation/externship hours following the completion of a minimum of 600 hours.
- The program is limited to an enrollment of 10 students. Program applicants must be at least 18 years old, high school graduates or have obtained a GED certificate and must have completed a CPR course at a Health Care Provider level. Applicants must be US citizens or legal residents for employment upon graduation. Applicants must complete 20 hours of "job shadowing".
- Tuition must be paid or payment arrangements must be made prior to the first day of class. Students who fail to do so will be dropped from the program.
- A Certificate of Completion is awarded after successful completion and full payment of the program.
- Students are responsible for their own transportation to the training center and to clinical facilities for patient contacts, as well as appropriate clothing for patient contacts.
- Applicants must have certification from a licensed physician that they are able to meet the physical requirements of the job (dexterity, visual acuity, full range of motion, etc.)
- Students are subject to dismissal for the following : Failure to maintain a 85% average in each class, failure to complete clinical hours, failure to meet attendance requirements, violation of code of conduct, non-payment. Termination date is defined as when the student is notified in writing by hand delivery or mail.
- Students may voluntarily withdraw from the program in writing by delivering a letter to the administrative staff by hand or by mail.
- *Idaho Center of Emergency Medical Training* is a drug-free institution. It reserves the right to drug test any student at any time at his or her expense, with or without cause. Students who refuse to comply with a drug test request, or who test positive for drugs or alcohol during class time, are subject to immediate dismissal from the program.
- It is the responsibility of the student to determine that they have the physical, mental, and emotional ability to safely participate in the program and be employed as an Expanded Function Dental Assistant.

Personal Statement

Your personal statement—consisting of responses to two prompts—is your chance to tell us who you are and what’s important to you. Think of it as your opportunity to introduce yourself to the people reading your application. Be open, be honest, be real. What you tell us in your personal statement gives readers the context to better understand the rest of the information you’ve provided in your application.

A couple of tips: Read each prompt carefully and be sure to respond to all parts. Use specific, concrete examples to support the points you want to make. Take time to write, rewrite and edit. Show it to a teacher, counselor or friend for comments, but make sure the words you use are your own.

Finally, relax. This is one of many pieces of information we consider in reviewing your application; an admission decision will not be based on your personal statement alone.

Instructions:

- Respond to both prompts, using a maximum of 1,500 words total.
- You may allocate the word count as you wish. If you choose to respond to one prompt at greater length, we suggest your shorter answer be no less than 300 words.
- Stay within the word limit as closely as you can. A little over — 1,512 words, for example — is fine.

Prompt #1 : Tell us about a personal quality, talent, accomplishment, contribution or experience that is important to you. What about this accomplishment or quality makes you proud and how does it relate to the person you are?

Prompt #2 : When did you become interested in this field and what have you learned about it (and about yourself) that has further stimulated your interest and reinforced your conviction that you are well suited to this field? What insights have you gained?

I, the undersigned, have received a copy, read and accept the conditions of this enrollment agreement. I agree to abide by the code of conduct outlined in the Dental Assistant Student Handbook.

Student Signature

Date

For Office Use Only :

Education Director

Date

Accepted Deferred Denied

Idaho Center of Emergency Medical Training Expanded Function Dental Assistant

DENTAL ASSISTING VERIFICATION OF JOB SHADOWING

The applicant listed below has applied for our Dental Assisting Program :

Student Name : _____

Please Print

Dear Doctor(s) and Dental Assistant(s):

The dental assisting faculty at ICEMT would like to thank all the volunteer offices/agencies that have allowed a prospective dental assisting student into their dental practice. We require all pre-dental assisting students to observe twenty hours. We are recommending this to provide potential students the opportunity to gain basic knowledge of the career that they have chosen. We appreciate the time that you have given to our students. In order that we continue to make improvements in this experience for students we would appreciate your brief response to the following questions.

Your name/organization: _____

Dates of student observation: _____ Number of hours spent observing: _____

Please identify any recommendation you have to improve this experience for students :

Signature of supervising dentist: _____

This form may be faxed, mailed or given to the student to return.