

DENTAL ASSISTING PROGRAM ENROLLMENT APPLICATION

BASIC INFORMATION			
FIRST NAME	M.I.	LAST NAME	SUFFIX (I.E. JR., SR.)
MAIDEN NAME (IF APPLICABLE)	GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	DATE OF BIRTH (MM/DD/YYYY)	U.S. CITIZEN? <input type="checkbox"/> YES <input type="checkbox"/> NO
IF YOU ARE NOT A U.S. CITIZEN PLEASE INDICATE YOUR STATUS <input type="checkbox"/> RESIDENT ALIEN <input type="checkbox"/> REFUGEE <input type="checkbox"/> ASYLEE <input type="checkbox"/> VISA		IF VISA, PLEASE INDICATE THE TYPE OF VISA	SOCIAL SECURITY NUMBER
RACE/ETHNIC BACKGROUND INFORMATION <input type="checkbox"/> AMERICAN INDIAN/ALASKA NATIVE <input type="checkbox"/> ASIAN <input type="checkbox"/> BLACK/AFRICAN AMERICAN <input type="checkbox"/> HISPANIC/LATINO <input type="checkbox"/> NATIVE HAWAIIAN/PACIFIC ISLANDER <input type="checkbox"/> WHITE <input type="checkbox"/> OTHER/UNKNOWN/MULTIPLE			
ARE YOU 18 YEARS OF AGE OR OLDER? <input type="checkbox"/> YES <input type="checkbox"/> NO	LEGAL GUARDIAN'S FIRST NAME	LEGAL GUARDIAN'S LAST NAME	
LEGAL GUARDIAN'S PHONE NUMBER	RELATIONSHIP TO LEGAL GUARDIAN		
PRESENT ADDRESS	CITY	STATE	ZIP
PERMANENT ADDRESS	CITY	STATE	ZIP
HOME PHONE NUMBER	CELL PHONE NUMBER	EMAIL ADDRESS	
EMERGENCY CONTACT(S) INFORMATION			
PRIMARY EMERGENCY CONTACT'S FULL NAME		EMERGENCY CONTACT'S PHONE NUMBER	RELATIONSHIP
SECONDARY EMERGENCY CONTACT'S FULL NAME		EMERGENCY CONTACT'S PHONE NUMBER	RELATIONSHIP
EDUCATIONAL AND EMPLOYMENT HISTORY			
PLEASE INDICATE YOUR HIGHEST LEVEL OF EDUCATION COMPLETED <input type="checkbox"/> HIGH SCHOOL <input type="checkbox"/> ADULT HIGH SCHOOL <input type="checkbox"/> VOCATIONAL DIPLOMA <input type="checkbox"/> GED <input type="checkbox"/> ASSOCIATE'S DEGREE <input type="checkbox"/> BACHELOR'S DEGREE <input type="checkbox"/> I DO NOT HAVE A HIGH SCHOOL DIPLOMA OR GED AND WILL NEED TO TAKE AN ENTRANCE EXAM*			
* Individuals that do not have a high school diploma or GED during the enrollment process must successfully pass an entrance exam to be admitted into the program			
SCHOOL NAME			
CITY	STATE	ZIP	GRADUATION DATE (YEAR)
PLEASE INDICATE YOUR CURRENT EMPLOYMENT STATUS <input type="checkbox"/> EMPLOYED: 1-10 HRS PER WEEK <input type="checkbox"/> EMPLOYED: 21-39 HRS PER WEEK <input type="checkbox"/> UNEMPLOYED: SEEKING EMPLOYMENT <input type="checkbox"/> EMPLOYED: 11-20 HRS PER WEEK <input type="checkbox"/> EMPLOYED: 40+ HRS PER WEEK <input type="checkbox"/> UNEMPLOYED: NOT SEEKING EMPLOYMENT			
EMPLOYMENT STATUS LENGTH: <input type="checkbox"/> LESS THAN A MONTH <input type="checkbox"/> 6 - 12 MONTHS <input type="checkbox"/> 2 - 5 YEARS <input type="checkbox"/> 1 - 6 MONTHS <input type="checkbox"/> 1 - 2 YEARS <input type="checkbox"/> 5 OR MORE YEARS			
ENROLLMENT PREFERENCES			
PREFERRED CAMPUS LOCATION <input type="checkbox"/> EAST CAMPUS <input type="checkbox"/> WEST CAMPUS		PREFERRED CLASS TIME <input type="checkbox"/> MORNING (9AM-12PM) <input type="checkbox"/> AFTERNOON (2PM-5PM) <input type="checkbox"/> EVENING (6PM-9PM)	
DO YOU HAVE ANY PREVIOUS DENTAL OFFICE WORK EXPERIENCE? <input type="checkbox"/> YES <input type="checkbox"/> NO			
IF YES, PLEASE BRIEFLY DESCRIBE			

APPLICATION CONTINUES ON NEXT PAGE

DO YOU HAVE ANY SPECIAL NEEDS OR ACCOMODATIONS THE ADMISSIONS REPRESENTATIVE SHOULD BE AWARE OF?

YES NO

IF YES, PLEASE BRIEFLY DESCRIBE

THERE ARE A NUMBER OF TUITION PAYMENT OPTIONS. PLEASE INDICATE WHICH YOU HAVE AN INTEREST IN DISCUSSING.

PAYMENT IN FULL UP-FRONT PRIVATE STUDENT LOANS MYCAA - LIMITED TO MILITARY SPOUSES
 MONTHLY PAYMENT PLANS CITY / COUNTY / GOVT GRANTS VA - GI BILL: MILITARY, SPOUSES, & DEPENDENTS

HOW DID YOU HEAR ABOUT ALTRAIN DENTAL ASSISTING ACADEMY?

NEWSPAPER / MAGAZINE TELEVISION COMMERCIAL REFERRAL FROM AN INDIVIDUAL
 INTERNET SEARCH RADIO COMMERCIAL OTHER _____

REFERRAL NAME

WHAT TIME DO YOU PREFER THAT OUR ADMISSIONS REPRESENTATIVE CONTACT YOU?

8:00AM - 10:00AM 12:00PM - 2:00PM 6:00PM - 8:00PM
 10:00AM - 12:00PM 2:00PM - 4:00PM 8:00PM - 10:00PM

I CERTIFY THAT THE INFORMATION ON THIS APPLICATION IS CORRECT AND COMPLETE. I UNDERSTAND THAT PROVIDING FALSE OR INCOMPLETE ANSWERS MAY RESULT IN DISCIPLINARY ACTION, INCLUDING DENIAL OF ADMISSION OR DISMISSAL AFTER ADMISSION. I AGREE TO ABIDE BY THE RULES, POLICIES, AND REGULATIONS OF ALTRAIN DENTAL ASSISTING ACADEMY WHILE ENROLLED.

APPLICANT'S PRINTED NAME

APPLICANT SIGNATURE

DATE

ALTRAIN DENTAL ASSISTING ACADEMY IS AN EQUAL OPPORTUNITY EDUCATIONAL INSTITUTION AND DOES NOT DISCRIMINATE ON THE BASIS OF RACE, COLOR, GENDER, AGE, RELIGION, NATIONAL ORIGIN, OR DISABILITY.

ADMISSIONS OFFICE USE ONLY

ADMISSIONS REPRESENTATIVE NAME _____ MEETING DATE _____ TIME _____

CAMPUS DETERMINED TO BEST FIT STUDENT'S NEED EAST CAMPUS WEST CAMPUS
TIME OF DAY THAT BEST FITS STUDENT'S NEED MORNING AFTERNOON EVENING
DESIRED START DATE _____

ADMISSIONS REPRESENTATIVE NOTES