



Continuing Education Application Dental Assisting Certificate Program

Students are admitted only in the Summer semester. Year: _____

Access to Austin Community College's programs or activities shall not be limited on the basis of race, color, creed, national origin, religion, age, gender, sexual orientation, political affiliation, or physical disability. Applications accepted year round.

Please Type or Clearly Print

Date of Birth ____/____/____

ACC Student ID: _____ e-mail address: _____
Leave blank if you do not have one

Name: _____
Last First Middle

Home Address: _____
Number & Street County City State Zip

Home Phone: _____ Alternate Phone: _____ Social Security No. _____

Please Complete: (for State Reporting Purposes only)

- Ethnicity/Race: Hispanic/Latino Black/African American Asian White
 American Indian/Alaskan Native Native Hawaiian/Pacific Islander Other
- Gender: Female Male

All students who enter the clinical setting (i.e. clinic, hospital, other) must meet "Community Standards" concerning **criminal background** screening and state **vaccination** requirements. Vaccinations can take up to 6 months to complete, so students are urged to plan accordingly. Additional information about the Dental Assisting Certificate Program is available at www.austincc.edu/ce/hpi. We may make exceptions regarding immunizations in process, but there are NO EXCEPTIONS to having background check completed at the time of application.

It is the student's responsibility to:
Return this application to the Dental Assisting Program Coordinator, ACC Highland Business Center (HBC), 5930 Middle Fiskville Road, Austin, Texas, 78752 with the checklist fully completed, and all required documentation enclosed. Incomplete applications will not be considered. This application must be submitted prior to registration. For assistance, please contact the program coordinator at 512-223-7090.

For Continuing Education Office Use Only

Accepted Rejected

Application Received – Date: _____
Added/Verified to Datatel – Date: _____
Petitioned – Date: _____

Reviewed By: _____
_____ Date: _____

Print Name and Phone Extension

Student Advised of Status – Date: _____ by email by mail by phone by message in person

Important: Documentation of immunizations ARE required at the time of application (see “Immunizations, Tests, and Background Check Required by State Law/Clinical Facilities” form). Program applications are NOT 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 form was signed by health care provider.

Application Checklist:

- _____ Completion of “**Immunizations**” form (attached)
- _____ Submission of criminal background check to PreCheck.com
- _____ Current **CPR Certification for Health Professionals from the American Heart Association**

Acceptance of an application does not guarantee a student a seat in the course. Students must attempt to register for classes during the Continuing Education open enrollment period for each semester. Classes may fill quickly, preventing a student from registering even though the student has completed the accepted application on file with the continuing education department. Students must notify the Health Professions Institute for Continuing Education of any change in applicant data. Failure to do so may result in the withdrawal of permission to register in the classes or the inactivation of the application.

I hereby certify that the information contained in this application is true and complete to the best of my knowledge. I understand that any misrepresentation or falsification of information is cause for denial of admission or expulsion from the College. I understand that the faculty and staff of the Health Professions Institute for Continuing Education will read the information contained in this application.

Signature of Applicant

Date

Immunizations, Tests, and Background Check Required by State Law/Clinical Facilities

Name: _____ SSN or ACC ID#: _____

Program: _____ Date of Birth: _____

<p>Criminal Background Check Please indicate the date you submitted your request to www.precheck.com for PreCheck to conduct the background check.</p>	<p>Date _____ (mm/dd/yy)</p> <p>Background check may not be more than 3 months old on the first day of class.</p>
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<p>Measles (Rubeola). Those born on or after January 1, 1957++ must show proof of either:</p>	
<p>A. Two doses of measles vaccine on or after their first birthday and at least 30 days apart OR *See note.</p>	<p>Date #1 _____ Date #2 _____ (mm/dd/yy) (mm/dd/yy)</p>
<p>B. Record of physician-diagnosed measles OR **See note.</p>	<p>Date _____ (mm/dd/yy)</p>
<p>C. Serologic test positive for measles antibody **See note.</p>	<p>Date _____ Result _____ (mm/dd/yy)</p>

<p>Mumps. Those born on or after January 1, 1957++, must show proof of either:</p>	
<p>A. One dose of mumps vaccine on or after their first birthday OR</p>	<p>Date _____ (mm/dd/yy)</p>
<p>B. Record of physician-diagnosed mumps OR **See note.</p>	<p>Date _____ (mm/dd/yy)</p>
<p>C. Serologic test positive for mumps antibody **See note.</p>	<p>Date _____ Result _____ (mm/dd/yy)</p>

<p>Rubella. <u>ALL</u> students must show proof of either: NEW REQUIREMENT</p>	
<p>A. One dose of Rubella vaccine on or after their first birthday OR</p>	<p>Date _____ (mm/dd/yy)</p>
<p>B. Record of physician-diagnosed Rubella OR **See note.</p>	<p>Date _____ (mm/dd/yy)</p>
<p>C. Serologic test positive for Rubella antibody **See note.</p>	<p>Date _____ Result _____ (mm/dd/yy)</p>

Hepatitis B. Must show proof of:	
A. Three doses of vaccine administered over a period of 4-6 months. The second dose of the vaccine must be at least 4 weeks after the initial dose. The third dose must be given at least 12 weeks after the second dose. OR	Date #1 _____ (mm/dd/yy)
	Date #2 _____ (mm/dd/yy)
	Date #3 _____ (mm/dd/yy)
B. Serologic test positive for Hepatitis B antibody **See note.	Date _____ Result _____ (mm/dd/yy)

Varicella. Must show proof of:	
A. Two doses of Varicella vaccine administered 4-8 weeks apart OR	Date #1 _____ Date #2 _____ (mm/dd/yy) (mm/dd/yy)
B. Serologic test positive for Varicella antibody OR **See note.	Date _____ Results _____ (mm/dd/yy)
C. Physician documented history or diagnosis of Varicella **See note.	Date Disease Occurred _____ (mm/dd/yy) Documented history after September 1, 1991 must have a month, day and year.
*Only one dose of Varicella vaccine is needed if the student received first dose before the age of thirteen (13).	

Diphtheria, Tetanus (Td) One dose within past 10 years at the time of application	Date _____ (mm/dd/yy)
Tuberculosis Test (PPD) Tuberculosis Skin Test (PPD skin test or chest x-ray) with a negative reading is required with the submission of application. (Test may not be more than 180 days old on the first day of class.)	Date _____ Results _____ (mm/dd/yy)
* Combined MMR Vaccine is vaccine of choice if recipients are likely to be susceptible. ** Must be the date of diagnosis or test collection; not when primary care provider signed immunization form. + Vaccines administered after September 1, 1991 shall include the MM/DD/YY each vaccine was given. ++ To be exempt from proof of measles and/or mumps, those born before January 1, 1957 must provide copy of photo ID.	

Physician or Approved Licensed Health Professional Information:	
Printed Name _____	
Address _____	
Signature of Primary Care Provider (only validates vaccination & PPD info above)	Date _____