



Application for Enrollment – Dental Assistant Program

Applicants must complete, sign, date, and return this form with a copy of your Diploma and official High School/College Transcript or GED/HiSET, requested attachment, and the \$35.00 application fee (if applicable – see page 4). The entire application packet should be mailed or hand-delivered to the following address:

Chief Officer of Education
Interfaith Education Center for Community Dental Care
210 Robert Rose Drive, suite 2
Murfreesboro, TN 37129

Full Legal Name:

Last (Maiden) First Middle

Social Security # _____ - _____ - _____ Date of Birth _____ / _____ / _____

Contact Information:

Email: _____

Phone:

Home (____) _____ - _____ Cell (____) _____ - _____ Work (____) _____ - _____

Mailing address: _____

City: _____ State: _____ Zip: _____

County: _____

Race: 1. Do you consider yourself to be Hispanic/Latino/Spanish Origin? ___ Yes ___ No

2. In addition, select one of the following racial categories to describe you:

___ Caucasian /White ___ African American ___ Asian ___ American Indian

___ Alaska Native ___ Native Hawaiian or Other Pacific Islander

___ Middle East ___ Other

Sex: Male Female

Circle Highest Grade Completed: 1 2 3 4 5 6 7 8 9 10 11 12 GED/HiSET

Most Recent High School Attended: _____

Location: _____

Did you graduate? yes no

Date (month/year) last attended and/or graduation: _____

Circle and List Highest Post-Secondary Level Completed (if applicable): 1yr 2yrs 3yrs 4yrs

Name/ Location	Program/ Hours & Degree Awarded	Dates Attended
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please indicate below, if you have previous training related to the program you have chosen:

High School (Tech Prep/Dual Enrollment) Post-Secondary Education

Are you presently employed? Do your work hours interfere with school hours?

Company Name and Address:

How did you hear about us? TV/Radio Family/Friend Web site
Recruitment event/guest presentation Sign Other (Explain _____)

Citizenship Code: (Must be completed; Foreign-born students must provide an Alien Registration Card or other proof of residency. Interfaith Education Center for Community Dental Care (IECCDC) is not approved to accept Student Visas, Employment Authorization Cards or International students with temporary status in the U.S.)

U.S. Citizen

Foreign Temp

Foreign Perm (*Alien Registration Number _____; must provide copy)

Are you currently incarcerated? Yes No

Do you have a criminal record involving a violent crime or have a criminal record within the past 3 years?

Yes No

Do you have reliable transportation with no citations for driving under the influence of alcohol or drugs, reckless driving, or license suspension for at least 3 years?

Yes No

Have you been free of alcohol and drug abuse/dependency for at least 3 years?

Yes No

Have you used illegal drugs or controlled substances in the past 3 years?

Yes No

Federal Law requires all male citizens or eligible noncitizens born on or after January 1, 1960, to register with the Selective Service. Chapter 759 of the Public Acts of 1984 provides that no person who is required to register with the Selective Service be eligible to enroll in any state post-secondary school until such person has registered with Selective Service.

You must indicate your status:

Registered (Selective Service# _____)

Not required to register:

Female

Member of the Armed Forces

Have not reached 18th birthday

Born before January 1, 1960

Permanent resident of the trust territory of the Pacific Island or Mariana Islands

Required registering, but not registered (*attach statement explaining why you are not registered)

I understand that withholding information requested on this application or giving false information may make me ineligible for admission to or continuation in Interfaith Education Center for Community Dental Care. With this in mind, I certify the above information to be correct and complete. Further, if I am admitted to Interfaith Education Center for Community Dental Care, I agree to abide by all the rules and regulations of this institution.

Applicant's Signature _____

Date _____

The application fee of \$35.00 can be paid via check or credit card. Checks should be payable to Interfaith Dental Clinic. Please call 615-921-5168 to pay via credit card.

NOTE: The application fee is waived if applicant attends a tour prior to the end of application period.

Application Packet (PART 1) Checklist:

_____ Application form which is completed, signed, and dated

_____ Official copy of your Diploma and official High School/College Transcript or GED/HISET (*NOTE: These can also be faxed directly from the school or testing body: 615-320-0613, Attention – Chief Officer of Education*)

_____ Requested attachment (references' page)

_____ \$35.00 application fee (made payable to Interfaith Dental Clinic) - ***THIS FEE IS WAIVED IF APPLICANT ATTENDS A TOUR PRIOR TO THE END OF THE APPLICATION PERIOD!***

The **entire** application packet should be mailed or hand-delivered to the following address:

Chief Officer of Education

Interfaith Education Center for Community Dental Care

210 Robert Rose Drive, suite 2

Murfreesboro, TN 37129

Applicants must list **two references (non-family members)** as part of the completed application packet.

Reference #1

Name: _____

Title: _____

Company/organization: _____

Contact Information:

Email: _____

Phone:

Home (____) ____ - ____ Cell (____) ____ - ____ Work (____) ____ - ____

Mailing address: _____

City: _____ State: _____ Zip: _____

Reference #2

Name: _____

Title: _____

Company/organization: _____

Contact Information:

Email: _____

Phone:

Home (____) ____ - ____ Cell (____) ____ - ____ Work (____) ____ - ____

Mailing address: _____

City: _____ State: _____ Zip: _____