Interfaith Education Center for Community Dental Care

**Application for Enrollment – Dental Assistant Program**

Applicants must complete, sign, date, and return this form and request an OFFICIAL copy of your 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 compete. 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
_____ Requested an OFFICIAL copy of your High School/College Transcript or GED/HiSET to be **sent directly from the institution to IECCDC** *(NOTE: These can also be faxed directly from the school or testing body: 615-921-5168, 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: _____