OSWEGO COUNTY BOCES
ADULT CAREER EDUCATION/CAREER SERVICES OFFICE
179 County Route 64, Mexico, New York 13114
(315) 963-4256

APPLICATION PROCEDURE FOR DENTAL ASSISTING PROGRAM

It shall be the policy of the Board of Cooperative Educational Services of Oswego County to provide equal opportunities for all persons affected by the myriad of operations of the Oswego County BOCES without regard to age, race, marital status, parental status, color, creed, religion or national origin.

To get started:

Fill out the Student Application Form (including the essay) and the Medical History Form "A"and **submit** both forms to the Adult Education Career Services Office at the address above.

Call 963-4256 to schedule an entrance test for the program, the Test of Adult Basic Education (the TABE). You cannot enter the program without having taken and passed the TABE. ***Your test results will be mailed to you.*** If you do not pass the test the first time, remedial help is available and you can take the test again when you are ready. TABE test results are valid for one year.

Immediately after applying:

Schedule a physical and have the physician complete the BOCES Physical Form B. This is the only form that will be accepted. **The signed, completed physical form must be submitted to the Career Services Office *before* you can be accepted into the program**. The date on the physical form cannot be more than one year prior to the start date of the program.

Contact your physician or one of the free Immunization Clinics in Oswego County (list enclosed) to **complete** the Immunization Record Form. **The signed, completed immunization form must be submitted to the Career Services Office *before* you can be accepted into the program.** Please read the form carefully, strict adherence to dates and times of shots is mandatory.

Distribute the two reference forms provided in the packet to the references you listed on your Student Application Form. **The forms must be returned directly to the Career Services Office and must be received *before* your Admissions Interview**. Telephone responses are not accepted. References must be non-related persons, and boyfriends or girlfriends are not appropriate. If you have worked within the last three years, one reference must be from an employer.

Contact your high school to request that an official signed and sealed copy of your high school transcript be sent directly to the Career Services Office. Do not have the transcripts sent to you. Those with a GED must submit a copy of their certificate *and* GED scores. **The high school transcripts or GED documentation must be received *before* your Admissions Interview.**

Submit college transcripts if you are seeking transfer credit for previous college course work. The transcripts must be official and ***must be submitted prior to the program start date in order*** for you to receive the transfer credit.

After passing the entrance (TABE) test:

Once you pass the entrance test and submit your 1.) Student Application, 2.) Medical History Form A, 3.) Essay, 4.) High School Diploma or GED documentation, and 5.) Two References, *you will be notified of your scheduled appointment for an Admissions Interview.* The Admissions Interview is a requirement for admission into the program and you will not be scheduled until all the items are in your file. If you cannot keep this appointment, please call 963-4256 to cancel and/or reschedule.

Finally:

Receive a letter of decision from the admissions committee. All completed admissions files are reviewed by an admissions committee and not everyone who applies is accepted into the program. Prospective Students should not assume they have been accepted until they receive a letter of acceptance.

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STUDENT APPLICATION FORM

DIRECTIONS: Please write or print clearly. Answer each question on **both sides**.

PART I

Program Title ______________________ Social Security# ______________

Name ______________________ Maiden or Prior Name ______________

Address ____
(STREET or RURAL ROUTE & BOX #) (CITY) (STATE) (ZIP CODE)

Phone Numbers: Home ______________ Message or Work ______________

E-mail Address: ______________

Highest High School Grade Completed? (Circle one) 8 9 10 11 12

High School Diploma? ______ Yes ______ No Year: ______________

Name of School: ____

GED? ______ Yes ______ No Year: ______________

Any education beyond High School? Yes No

If yes, please list name and address of school and dates attended. ______________

____

____

PART II

Work Experience: (Job held within last 12 months)

1. Type of Work Performed: ______________
2. Length of Time: ______________
3. Name & Address of Employer: ______________
____
4. Are you still employed? ______ Yes ______ No
If no, why did you leave this employment? ______________
____
____
____

Employment Prior to the Above Listing:

Place of Employment	Title/Duties	Dates of Employment

References: Both references must be non-related persons. If you have worked within the last three years, one reference must be an employer.

1. Name: ______________________________
   Address: ______________________________
   (STREET or RURAL ROUTE & BOX #) (CITY) (STATE) (ZIP CODE)
2. Name: ______________________________
   Address: ______________________________
   (STREET or RURAL ROUTE & BOX #) (CITY) (STATE) (ZIP CODE)

PART III

1. On a separate piece of paper, please write in your own words a legible hand-written 250-word essay explaining why you want to become a dental assistant.

2. Have you ever been convicted of a crime (felony or misdemeanor) in any state or country?
   ______Yes ______ No

3. Have you ever been charged with a crime (felony or misdemeanor) in any state or country, the disposition of which was other than by acquittal or dismissal?
   ______Yes ______ No

AFFIRMATIVE ACTION POLICY

It shall be the policy of the Board of Cooperative Educational Services of Oswego County to provide equal opportunities for all persons affected by the myriad operations of the Oswego County BOCES without regard to age, race, sex, marital status, disabilities, creed, religion or national origin.

It is understood and agreed that all the information I have provided on this application is true, correct and complete. If accepted for training, I understand that any misstatement or omission of fact on the application may result in my dismissal.

______________________________ ______________________________
SIGNATURE OF APPLICANT DATE

8/5/03

OSWEGO COUNTY BOCES
Career Services Office
179 County Route 64, Mexico, New York 13114

MEDICAL HISTORY FORM "A"

DIRECTIONS: Please write or print clearly. Answer each question on both sides.

Applicant's Name:____ Sex: ❑ Female ❑ Male

Date of Birth: ________________________

CURRENT HEALTH

Please provide details/dates for the following:

1. Present health status (check one): ❑ Poor ❑ Fair ❑ Good ❑ Excellent

2. Are you presently being treated for any condition or disease? ❑ Yes ❑ No
   If yes, state details:
   ____
   ____
   ____

3. Name/address of Health Care Professional treating you:
   ____
   ____

4. Date of last health exam: ______________________ Last dental exam: ____________________

5. List current medications, including over-the-counter drugs, vitamins, prescribed drugs:
   ____
   ____

6. Allergies (check all that apply and provide details):
   ❑ Drugs ____
   ❑ Foods ____
   ❑ Contact Substances ____
   ❑ Environmental Factors ____

I have never abused or been addicted to depressants, stimulants, narcotics, alcohol or other substances that may alter my behavior.

❑ Yes, I have. If yes, explanation: ______________________________________
❑ No, I have not.

________________________________ ________________________________
Signature of Applicant Date

(continued on other side)

8/9/06

HEALTH HISTORY

Have you or any member of your immediate family ever had:

	No	Yes*	Self	Family Member
Head or spinal injuries?	❑	❑	❑	❑
Vision problems?	❑	❑	❑	❑
Seizures, fits, convulsions or fainting?	❑	❑	❑	❑
Hearing problems?	❑	❑	❑	❑
Extensive confinement by illness or injury?	❑	❑	❑	❑
Cardiovascular disease?	❑	❑	❑	❑
Tuberculosis?	❑	❑	❑	❑
Syphilis?	❑	❑	❑	❑
Gonorrhea?	❑	❑	❑	❑
Gastrointestinal ulcer?	❑	❑	❑	❑
Nervous stomach?	❑	❑	❑	❑
Rheumatic fever?	❑	❑	❑	❑
Asthma?	❑	❑	❑	❑
Kidney disease?	❑	❑	❑	❑
Muscular disease?	❑	❑	❑	❑
Suffering from any other disease?	❑	❑	❑	❑
Permanent defect from illness, disease or injury?	❑	❑	❑	❑
Mental illness?	❑	❑	❑	❑
Any other nervous disorder?	❑	❑	❑	❑
Learning disability?	❑	❑	❑	❑

*If you answered "yes" to any of the above questions, please explain:

____

____

____

____

The law prohibits discrimination because of age, race, sex, marital status, disabilities, creed, religion, or national origin and requires affirmative action in the hiring of the handicapped.

The information that I have provided on this questionnaire is accurate to the best of my knowledge. I have read, understand, and agree that BOCES will require a medical examination and if further medical information is required, I agree to provide a signed release statement as requested to secure the information.

This and other medical information will be held in strict confidence. It will be released only where required by law. Non-confidential information regarding work restrictions relating to job assignment will be provided to management and personnel.

______________________________ ______________________

Signature of Applicant Date

Oswego County BOCES
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179 Co. Rte. 64, Mexico NY 13114

Dental Assisting Program
PHYSICAL EXAMINATION FORM "B"
(to be completed by your physician)

Applicant's Name ______ SS# ______ Age ______ Date of Birth ______

Address ______ City ______ State ______ Zip ______

PHYSICIAN'S CERTIFICATE
I Certify That I Have Examined ______
Please Print Applicant's Name

He/She is physically qualified... ☐ He/She is not physically qualified... ☐
to participate in the Dental Assisting program which requires the physical ability to withstand prolonged periods of standing; hear and see accurately; calculate proportions, determine size; perform measurements. Finger dexterity and hand/eye coordination are also required; the ability to follow written and oral directions and to communicate orally and in writing; freedom from communicable diseases and freedom from addiction to alcohol or drugs.

Examination Date ______ Print Name of Examining Doctor ______ Signature of Examining Doctor ______

HEALTH HISTORY: Physician, please circle YES or NO to indicate if applicant has or has not experienced any of the following symptoms or diseases. If YES, please indicate date.

		DATE			DATE
YES/NO	Decreased Hearing		YES/NO	Ear Infections, Frequent	
YES/NO	Dizzy Spells/Fainting Spells		YES/NO	Head Injuries	
YES/NO	Vision Problems		YES/NO	Eye Infection, Frequent	
YES/NO	Nose Bleeds, Recurrent		YES/NO	Hay Fever/Allergies	
YES/NO	Upper Respiratory Infection		YES/NO	Asthma/Wheezing	
YES/NO	Chest Pain		YES/NO	Irregular Pulse	
YES/NO	High Blood Pressure		YES/NO	Heart Murmur/Palpitations	
YES/NO	Varicose Veins/Phlebitis		YES/NO	Loss of Appetite/Weight Loss	
YES/NO	Gastrointestinal Disorders		YES/NO	Jaundice/Hepatitis	
YES/NO	Hernia		YES/NO	Urine Infections, Frequent	
YES/NO	Kidney Stones		YES/NO	Venereal Disease	
YES/NO	Anemia		YES/NO	Cancer	
YES/NO	Diabetes		YES/NO	Thyroid Disease	
YES/NO	Convulsions/Seizures		YES/NO	Stroke	
YES/NO	Headaches, Frequent		YES/NO	Arthritis/Rheumatism	
YES/NO	Back Pain/Spinal Injury		YES/NO	Bone Fracture/Joint Injury	
YES/NO	Gout		YES/NO	Skin Problems	
YES/NO	Nervousness		YES/NO	Depression	
YES/NO	Mental Illness		YES/NO	Menstrual Problems	

Any Childhood Diseases (please list): ______

Describe any of the above symptoms or diseases circled "yes": ______

List any injuries/illnesses and/or operations: Year ______ Year

________________________ ______ ________________________ ______
________________________ ______ ________________________ ______
________________________ ______ ________________________ ______

List all medications applicant is now taking or has taken in past two years:

____
____
____

General Appearance and Development (circle one): Good Fair Poor

Ht. ______ Wt. ______ Temp. ______ Pulse ______ Respiration ______
Blood Pressure: Systolic ______ Diastolic ______

Throat: ____

Thorax: ____

Heart: ____
If organic disease is present, is it fully compensated? ________________

Lungs: ____

Abdomen: ____
Scars ________________________________
Abnormal masses ________________________________
Tenderness ________________________________

Hernia: Yes No If so, where? ________________ Is truss worn? Yes No

Gastrointestinal:
Ulceration or other disease? Yes No

Genito-Urinary: Scars ________________________________
Urethal Discharge ________________________________

Reflexes: Romberg
Pupillary Light (R) (L) Right Knee Jerks Normal Increased Absent
Accommodation Right ______ Left ______ Left Knee Jerks Normal Increased Absent

Musculoskeletal System: Upper ________________________________
Lower ________________________________
Spine ________________________________

REMARKS: ____
____
____
____
____
____
____

OSWEGO COUNTY BOCES
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STUDENT IMMUNIZATION RECORD FORM

Student Name: ______________________________ SSN: ____________

Student Address: ______________________________ Date of Birth: ____________

NYS Public Health Law requires post-secondary students to show protection against measles, mumps, and rubella:

Please note: MMR Vaccine is recommended for all measles vaccinations to provide increased protection against all three vaccine-preventable diseases: measles, mumps and rubella.
- Individuals should not be pregnant at the time they receive the vaccine.
- Individuals should not become pregnant for 3 months after receiving the MMR vaccine.
- Individuals should discuss questions and concerns with their physician.

REQUIRED: Measles (Rubeola) **Immunity**: Must have one of the following:
- Two (2) dates of Measles (Rubeola) Immunization (both must be given after 1967 and on or after the first birthday: 1) ____________ 2) ____________

or - Date of Measles Titer: ____________ Results: ____________

or - Date of physician-diagnosed measles disease AND signature of diagnosing physician: ____________ ____________
Date Signature

REQUIRED: Rubella (German Measles) **Immunity**: Must have one of the following:
- Date of at least one (1) Rubella Immunization (must be on or after first birthday): ____________

or - Date of Rubella Titer: ____________ Results: ____________
NOTE: Physician diagnosis is not acceptable for rubella immunity.

REQUIRED: Mumps Immunity: Must have one of the following:
- Date of at least one (1) mumps immunization (must be on or after first birthday): ____________

or - Date of Mumps Titer: ____________ Results: ____________

or - Date of physician-diagnosed mumps disease AND signature of diagnosing physician: ____________ ____________
Date Signature

Additional vaccines and testing for Oswego County BOCES Health Occupations students:

REQUIRED: Tetanus (TD): Date of last booster (must be within last ten years): ____________

REQUIRED: Mantoux (PPD) Test (must be no earlier than 2 months prior to start date of the class):
Date of Mantoux: ____________ Results: ____________ Date Results Recorded: ________

RECOMMENDED: Hepatitis B Vaccination Series:
- For students choosing to have the Hepatitis B Series:
Date of first shot: ____________ Second shot: ____________ Third shot: ____________

or - For students declining the Hepatitis B Series, please sign the following statement:

I understand that due to my occupational exposure to blood or other potentially infectious materials, I may be at risk of acquiring hepatitis B virus (HBV) infection. However, I decline hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring hepatitis B, a serious disease. If in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with hepatitis B vaccine, I can receive the vaccination at a later time.

______________________________ ____________
Student Signature Date

______________________________ ____________
Signature of Physician Date

IMMUNIZATION CLINICS*

Vaccinations may be received by any Oswego County Resident FREE OF CHARGE

Immunizations and screening tests are available on a walk-in basis at the following locations:

Location:	**Day of Week:**	**Month(s):**	**Time:**
Oswego Preventive Health Clinic County Health Dept. 70 Bunner Street	every Friday	every month	12:30-3:30PM
Pulaski Court House	every Friday	every month	9:00 to 11:00AM

* Any questions regarding immunizations may be directed to:
the Oswego County Health Department (315) 349-3545 or the Pulaski Health Clinic (315) 298-2233
Monday through Friday, 8:30 AM to 4:00 PM

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REFERENCE FORM

TO THE APPLICANT: Please fill out your name, program and semester for which you are applying. Give one form to each of your references. Both must be non-related persons. If you have worked within the last three years, one reference must be an employer.

NAME: ______________________ **PROGRAM:** ______________________
SEMESTER (please check): ❑ Fall ❑ Spring ❑ Summer

TO THE REFERENCE WRITER:
The applicant listed above has applied for admission into our program. Please indicate how long you have known the above applicant and the capacity in which you have known them. Include any attributes they possess that would be valuable for the profession they are seeking. Additionally, please indicate any reservation you have regarding the applicant's ability to successfully complete the program. Please return promptly to the above address.

Reference writer's:

Name: ______________________ Telephone: ______________

Address: ____

Organization: ______________________ Title: ______________

Signature: ______________________ Date: ______________

8/9/06 jkj

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Address: ______________________________

Organization: ______________________________ Title: ______________

Signature: ______________________________ Date: ______________

8/9/06 jkj