**Dental Hygiene Program Application Form**

Fill in each statement in typed format. Sign and date the bottom in handwritten format.

Name (Last, First, Middle Initial): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address (number, street, city, state, zip): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone (cell or home, include zip code): \_\_\_\_\_\_\_\_\_\_- \_\_\_\_\_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dallas College ID (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List of all high schools attended in order of most recent: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List of all college’s attended in order of most recent: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Applicant’s Signature            Date

**Students’ Responsibility Form**

Review and **initial** each statement indicting you have read and agree to each responsibility and sign at the bottom.

\_\_\_\_\_\_\_\_ I testify that information included in this packet is truthful and accurate. I acknowledge any information found to be incorrect or dishonest will exclude my eligibility from participating in the Dallas College Dental Hygiene Program.

\_\_\_\_\_\_\_\_ I understand submitting incomplete information in my application packet will disqualify my entire application.

\_\_\_\_\_\_\_\_ I acknowledge that Dallas College reserves the right to make changes to its application process and that completion of the application does not constitute a contract, expressed or implied, between any applicant, student, or faculty member at Dallas College.

\_\_\_\_\_\_\_\_ I accept the responsibility of informing the admissions office of any change in my status, address, telephone number, or other information that would affect my application status.

\_\_\_\_\_\_\_\_ I am aware that I will be required to undergo a criminal background check and periodic drug screening once accepted into the Dallas College Dental Hygiene Program and that my continuation in the program is conditional based on those results.

\_\_\_\_\_\_\_\_  I have thoroughly read the information packet and am informed of the criteria and procedures for selection, goals of the program, curricular content, course transferability, scope of practice, the employment opportunities for dental hygienists and the policies on bloodborne and infectious diseases.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Applicant’s Signature            Date

**Dallas College Dental Hygiene Program Professional Reference Form**

The applicant is requesting a professional reference for application to the Dallas College Dental Hygiene Program. We appreciate you taking time to complete the questionnaire.

This form must be completed, signed and received by **January 20, 2026**.

Return the form by:

* + 1. Emailing the form to dhappointments@DallasCollege.edu; subject line: REFERENCE FORM **OR**
		2. Place the form in a sealed envelope, sign across the flap, and give to the applicant

Your reference will remain anonymous to the applicant.

Applicant’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In what capacity do you know the applicant? \_\_\_\_\_ Employer \_\_\_\_\_ Educator \_\_\_\_\_\_ (Other, please explain)

How long have you known the applicant? \_\_\_\_\_\_\_\_\_\_\_\_\_

**Rating Scale**
5 - Excellent | 4 - Above Average | 3 - Meets Expectations | 2 - Below Average | 1 - Poor

**1. Communication and Teamwork**

* **Criteria:**
	+ Clear, concise, and professional communication skills (verbal and written).
	+ Demonstrated ability to work collaboratively with interdisciplinary teams.
	+ Conflict resolution and adaptability in team settings.

| **Score** | **Description (Circle the best response)** |
| --- | --- |
| 5 | Outstanding communication and teamwork; inspires collaboration. |
| 4 | Strong communication and teamwork; minor areas for improvement. |
| 3 | Adequate communication and teamwork; meets basic standards. |
| 2 | Communication or teamwork issues occasionally observed. |
| 1 | Significant challenges with communication or collaboration. |
|  | Unable to access |

**2. Dependability/Attendance**

* **Criteria:**
	+ History of strong attendance and being on time.
	+ Flexible and dependable during unexpected situations.
	+ Dependability/attendance had a positive impact on the team.
	+ Consistent follow through on commitments or assignments
	+ Self-motivated.

| **Score** | **Description** |
| --- | --- |
| 5 | Exceptional dependability/attendance, consistently goes above and beyond. |
| 4 | Strong dependability/attendance; occasionally exceeds expectations. |
| 3 | Satisfactory dependability/attendance; meets standard expectations. |
| 2 | Inconsistent dependability/attendance, or minimal evidence of dependability. |
| 1 | Poor dependability/attendance; lacks urgency to be on time. |
|  | Unable to access.  |
| \_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
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**3. Critical Thinking and Problem-Solving (Circle the best response)**

* **Criteria:**
	+ Ability to assess situations and make sound decisions.
	+ Demonstrated critical thinking and innovation in problem-solving.
	+ Effective handling of complex or unexpected challenges.
	+ Well-organized

| **Score** | **Description** |
| --- | --- |
| 5 | Exceptional critical thinking; anticipates and resolves challenges proactively. |
| 4 | Strong problem-solving skills; effective in most situations. |
| 3 | Satisfactory decision-making and problem-solving abilities. |
| 2 | Limited critical thinking; struggles with complex challenges. |
| 1 | Poor problem-solving skills; makes frequent errors in judgment. |
|  | Unable to access. |

**4. Commitment to Professionalism and Ethics**

* **Criteria:**
	+ Adherence to ethical standards and professional behavior.
	+ Demonstrates integrity, accountability, and reliability.
	+ Self-motivated
	+ Consistently displays neatness and grooming

| **Score** | **Description** |
| --- | --- |
| 5 | Exemplifies professionalism and ethics; a role model for others. |
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| 3 | Meets professional and ethical expectations consistently. |
| 2 | Inconsistent professionalism or ethical adherence. |
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Would you hire, rehire, or recommend this person for a healthcare position? Yes No Maybe

Why? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is there anything else you think we should know about the applicant? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Business/Company Institution: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Initials: \_\_\_\_\_\_\_\_\_\_ I attest that I am an educator or employer of the applicant and am not a family member or friend.

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In what capacity do you know the applicant? \_\_\_\_\_ Employer \_\_\_\_\_ Educator \_\_\_\_\_\_ (Other, please explain)

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Would you hire, rehire, or recommend this person for a healthcare position? Yes No Maybe

Why? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is there anything else you think we should know about the applicant? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Business/Company Institution: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Initials: \_\_\_\_\_\_\_\_\_\_ I attest that I am an educator or employer of the applicant and am not a family member or friend.

## **Dental and Dental Assistant Point Considerations Form (if applicable)**

**This form must be submitted with your application packet for consideration for admission points.**

**🞎 I have completed dental school in a foreign country.**

🞎 You must attach a copy of your College Transcript or License.

**🞎 I have Dental Assisting National Board (DANB) Certification with over 1200 or more hours of current dental assistant experience within the past 24 months.**

🞎 You must attach a copy of your DANB CDA certificate.

🞎 You must attach the employer verification form demonstrate your 1200 hours.

**🞎 I am a Registered Dental Assistant (RDA) with 1200 or more hours of current dental assistant experience within the past 24 months.**

 🞎 You must provide your RDA # \_\_\_\_\_\_\_\_ and State of issue: \_\_\_\_\_\_\_\_.

🞎 You must use the employer verification form to demonstrate your 1200 hours.

**🞎 I completed the Dallas College Dental Assistant Program on \_\_\_\_\_\_\_\_\_\_\_\_** (date).

🞎 You must attach a copy of your Continuing Education completion certificate.

 🞎 Provide your Texas State Board of Dental Examiners (TSBDE) RDA # \_\_\_\_\_\_\_.

**DENTAL ASSISTANT EMPLOYMENT VERIFICATON**

**The work hours in a dental office must equal to a minimum of 1200 hours of current experience within the last 24 months. Use additional forms if necessary.**

**Declaration of certifying dentist:**

Name of Certifying Licensed Dentist:

Street Address of Dental Office:

City/State/Zip:

Office Phone: Alt. Phone:

I declare that \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ was employed by me as a dental

assistant, working \_\_\_\_\_\_\_ hours per week from \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

 MM/DD/YYYY MM/DD/YYYY

**I declare under penalty of perjury that the above information is true and correct.**

Signature of Certifying Dentist Date

State in Which Dentist is Licensed \_\_\_­­­­\_\_\_\_\_\_\_\_\_\_ Dentist License #\_\_\_\_\_\_\_\_\_\_\_\_\_\_

##

**PHYSICAL EXAM FORM**

**You must use this physical exam form. The form must be completed by a physician or nurse practitioner.**

**Applicant Full Name** **Date of Birth**

**Email Address** **Student ID #**

**Height** **Weight**  **Temp** **Blood** **Pressure** **Sex**

**Vision** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Glasses** \_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Contact** **Lenses** R \_\_\_\_\_\_\_\_\_\_ L \_\_\_\_\_\_\_\_\_\_

**History: Include any significant information regarding previous medical and surgical conditions and use of alcohol and/or drugs.**

**General Appearance:**

|  |  |  |  |
| --- | --- | --- | --- |
| Normal | Check each item in appropriate column | Abnormal | Describe every abnormality in detail (attach additional sheet if necessary). |
|  | Eyes-ears-nose-throat |  |  |
|  | Mouth-teeth-neck |  |  |
|  | Thyroid |  |  |
|  | Heart and Vascular |  |  |
|  | Lungs |  |  |
|  | Abdomen and Viscera |  |  |
|  | Hernia |  |  |
|  | Scars |  |  |
|  | Back, vertebrae |  |  |
|  | Extremities |  |  |
|  | Skin |  |  |
|  | Neurological |  |  |

**Physician Recommendation**

Based upon your physical examination, is the applicant free of any restrictions in his/her ability Yes \_\_\_\_ No \_\_\_\_

to turn and/or move heavy objects? If “no,” please describe:

If the applicant able to see and hear adequately to practice as a health care professional? Yes No

If “no,” please explain:

Is the applicant free of any pathological conditions either physical or mental that would interfere Yes No

With the practice of a health care profession? If “no,” please describe:

**PHYSICIAN OR NURSE PRACTITIONER SIGNATURE IS REQUIRED FOR THIS FORM TO BE ACCEPTED:**

Signature of Physician or Nurse Practitioner Date

Printed Name of Physician or Nurse Practitioner

Phone Number ( )

Address of Physician or Nurse Practitioner:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PHYSICAL EXAM FORM – Page 2**

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB:\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, TX \_\_\_

Phone: (C) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (H) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (W) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Health Questionnaire: (To be completed by applicant):**

Yes: \_\_\_\_\_ No: \_\_\_\_\_ Do you have any physical limitations that would affect your ability to lift, turn or transfer patients?

Yes: \_\_\_\_\_ No: \_\_\_\_\_ Do you have any limitations in use of your senses, such as in sight or

 hearing, which would limit your ability to practice a health profession?

Yes: \_\_\_\_\_ No: \_\_\_\_\_ Do you have any other condition that might interfere with your ability to

 practice in the health professions?

If you answered ‘Yes’ to any of the above, please explain your limitations in detail:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any medications you take on a regular basis or on a frequent basis during the past twelve months:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

History: Include any significant information regarding previous medical, surgical, psychiatric conditions and use of alcohol and/or drugs.:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_