National School of Dental Assisting
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NATIONAL SCHOOL OF DENTAL ASSISTING

Dental Assisting Program
Approved and Regulated by the Washington State Workforce Training And Education Coordinating Board

APPLICATION

Student's Name:_____

Address:_____

City:_____ State:_____ Zip:_____ Social Security Number:_____

Home Phone:_____ Work Phone:_____

Date of Birth:_____ Have you ever been convicted of a drug-related offense? ❑ Yes ❑ No

In case of emergency, whom should we contact? Name:_____ Phone:_____

EDUCATIONAL DATA

Circle the highest grade competed: 1 2 3 4 5 6 7 8 9 10 11 12 *College:* Fresh. Soph. Jr. Sr. *Grad. Degree:* ❑Yes ❑No
❑Yes ❑No Completion date:_____

SCHOOL	NAME AND LOCATION	GRADUATED (Y/N)	MAJOR	GPA
Grammar School				
High School				
College				
Other (Specify)				

Subjects of Special Study:_____

Special Training and Skills:_____

EXPERIENCE

Please state briefly why you wish to attend dental assisting school. *(You may use the space provided below, or attach a separate piece of paper.)*

_____

_____

_____

Please describe any dental office experience you have had up to now. *(You may use the space provided below, or attach a separate piece of paper.)*

_____

_____

_____

REFERENCES

Character References: Give the names of three persons not related to you, whom you have known at least one year.

NAME	ADDRESS	PHONE	BUSINESS
1.			
2.			
3.			

Do you authorize CSDA to contact your references? ❑Yes ❑No

What session you are interested in applying for?

_____

Dental Assistant:
I certify that all the information provided is complete and accurate to the best of my knowledge.

Applicant's Signature:_____ Date:_____