

Perspective Student:

Thank you for expressing interest in the Apollo School of Allied Health Professional's Dental Assisting Program. We are accepting applications for the upcoming academic year. This program is a **full-time, 10-month program. Each August, we will enroll 15 students in the evening program.** Attached are the application materials for the Dental Assistant Program. Applications are processed on a first-come, first-served basis and are kept on file for 3 years from the date of receipt.

**The fulltime evening classes** are held Monday through Thursday from 6:00 p.m. to 10:00 p.m. There will also two Fridays a month (10:00am-3:00pm) classes. There will be some exception to these hours such as the 200-hour practicum near the completion of the program. Practicum hours will be approximately 7:30 a.m. - 4:30 p.m. (*Hours vary per facility*).

If you are interested in the program, please begin the application process immediately upon the receipt of these materials. If you have any questions or concerns, please contact me by phone at 419-998-2981 or by e-mail at [joy.mendez@apollocc.org](mailto:joy.mendez@apollocc.org)

Sincerely,

Joy Mendez  
Allied Health Program Manager

**Apollo Academy of Medical Careers**  
**3325 Shawnee Road**  
**Lima, OH 45806**  
 APPLICATION – Dental Assisting Program

Complete and return form to Apollo Career Center. Application fee of \$30 is to be submitted with the application. DO NOT put cash in the mail. Check or money order should be payable to Apollo Career Center.

Date \_\_\_\_\_

**A. Identification**

1. Name in full \_\_\_\_\_  
 (Last) (First) (Middle) (Maiden)

2. Mailing Address \_\_\_\_\_  
 (Number / Street / PO Box/ or RR) (City) (State) (Zip)

3. Phone # \_\_\_\_\_ Cell # \_\_\_\_\_

4. Social Security Number \_\_\_\_\_

5. \*Email Address \_\_\_\_\_

\*Primary means of communication will be through your email account. If you do not have one please use the free resources through msn, yahoo, google, etc... to obtain a free account. An active email is required for federal financial aid and will be used to notify you of various things throughout your schooling and your status in the program. If you have concerns regarding this please let me know.

**B. Education**

1. Are you a high school graduate? YES NO WILL BE on \_\_\_\_\_

- If yes, list name and address of the high school from which you graduated & date of graduation.

\_\_\_\_\_  
 (Name) (Address) (Date)

- If no, do you have a GED certificate? YES NO  
 If yes, List name and address of the school from which you received your certificate & date.

\_\_\_\_\_  
 (Name) (Address) (Date)

2. List any other school(s) that you have attended since high school.

School Name	Address	Date Attended	Area of Study

- Have you ever been in a dental assisting program? YES NO  
 If yes, List school and date.

\_\_\_\_\_

**Read the following BEFORE you sign. Your signature will indicate that you have read and understand.**  
If you do not understand, please ask for an explanation BEFORE you sign.

I, \_\_\_\_\_, understand that

1. This is only an application and does NOT assure me of enrollment into the school.
2. All factors of the entrance requirements are reviewed by an Admission Committee.
3. I will accept the decision of the admission committee.
4. If I am enrolled the school has the right to ask for my resignation at any time, if I fail scholastically, or do not meet the other standards of the program.
5. Graduating from this program does not guarantee that I will be eligible to take the CODA Examination.

\_\_\_\_\_  
(Signature of Applicant)

\_\_\_\_\_  
(Date)

## Admission Policy

It is the policy of Apollo Career Center that education activities, employment, practices, programs, and services are offered without regard to race, color, national origin, sex, religion, age or disability.

The admission policy of the Dental Assisting Program assists the Admission Committee to select candidates who will be successful in the program.

The following is the procedure for being accepted as a candidate for the Dental Assisting Program.

1. Request an application packet. The packet contains an application, work, and personal reference forms, request forms for high school or G.E.D. transcript, and one (1) copy of the admission policy. These forms need to be completed and processed as indicated on the enclosed instruction sheet.

**Complete the following step that applies to you:**

- a. If you are a high school graduate, complete the form, "Request for High School Transcript" and submit it with any required fee to your high school for them to mail to Apollo School of Dental Assisting
- b. If you have a GED diploma, complete the transcript form from the Ohio Department of Education and submit it with the required fee to the appropriate agency. You can go online to find the form:  
<https://ged.com>
- c. If you are currently in high school, complete the "Request for High School Transcript" for a current transcript

2. Submit the application and the application fee of \$30. Applications are reviewed on a first-come, first served basis. There is **NO REFUND** of fees paid in the admission procedure.
3. Request and submit an **OFFICIAL** copy of your high school or equivalency transcript.
4. Required references: Two (2) positive personal references from persons **NOT RELATED** to the applicant and one (1) positive work reference from the current or most recent employer are required. **THE PERSON GIVING THE REFERENCE MUST MAIL references to Apollo. REFERENCES WILL NOT BE ACCEPTED FROM THE APPLICANT. The applicant does NOT have the right to review these confidential materials.**
5. The applicant is required to take the **WorkKeys Assessment** at Apollo Career Center. Assessment **MUST** show aptitude for Dental Assisting.  
Areas of testing are ACT WorkKeys Applied Math, Graphic Literacy, and Workplace Documents. If the applicant is unsuccessful with this test after two attempts, documentation of successful remedial work must be submitted before the third and final test can be schedule.

**Criteria for Being Scheduled for the WorkKeys Test:**

When ALL of the following items have been submitted to Apollo, you will be notified of a test date:

- Application
- Application fee
- High School Transcript or Transcript of Equivalency
- 2 Positive Personal References
- 1 Positive Work Reference
- 1 Signed copy of Admission Policy (a copy will be retained to you.)

6. If applicants meet all of the above criteria, they will be scheduled for an admission interview.

7. The applicant is informed in writing of the decision of the Admission Committee. The decision is based on high school grades or equivalency scores, positive references, interview, and Assessment Test.
8. The applicant is required attend the Professional Development class prior to starting school. This date is listed on the program calendar.
9. The applicant is required to have a **physical examination**, at his/her own expense. Included will be required diagnostic screening, as well as proof of immunity to identified communicable disease. It is PREFERRED that the applicant is completes the physical prior to starting the Dental Assisting Program but completion is mandatory by the end of the first quarter of training. Students that do not meet this requirement will not meet the course requirements for Clinical I and will be removed from the program.
10. The applicant is required to have **basic computer knowledge** prior to starting the Dental Assisting Program.
11. The applicant is required to be currently certified in **American Heart Association Basic Life Support (Healthcare Provider) CPR**. It is PREFERRED that the applicant is certified prior to starting the Dental Assisting Program but certification is mandatory by the end of the first quarter of training. Students that do not meet this requirement will not meet the course requirements and will be removed from the program.
12. Clinical and practicum sites used by the program can require drug screenings and background checks on any personnel in the facility; therefore, students will be required to have a drug screening and background check before starting practicum rotations. If, due to the results of the drug screen or background check, a student would be denied access to a healthcare facility, they will be dismissed from the program on the basis of not being able to meet the practicum hours requirement of the program. Applicants need to be aware that most employers now perform background checks before hiring new employees and certain disqualifiers, such as a felony and/or some misdemeanors, will prohibit them from finding employment and/or obtaining credentialing in their chosen profession upon graduation.

I, \_\_\_\_\_, have read and understand what is required of me to become a candidate for the Dental Assisting Program.

\_\_\_\_\_  
(Signature of Applicant)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Signature of the DA Program Manager)

\_\_\_\_\_  
(Date)



I, \_\_\_\_\_, hereby give the Faculty of Apollo Career Center permission to review my application materials for the purpose of determining my acceptability as a candidate for the Dental Assisting Program.

\_\_\_\_\_  
(Signature of Applicant)

\_\_\_\_\_  
(Date)

**Required Drug Testing for Admission**

The following is a written policy statement for Apollo School of Dental Assisting in which the program must ensure that students will provide safe and high quality patient care services while engaging in official school educational activities.

All newly accepted students may be subject to a 10 panel urine drug screening test as a part of admission into the practicum portion of the program. This test will be conducted as a part of pre-enrollment health requirements and/or by the beginning of the practicum portion of the program.

A positive confirmed result for the drug test shall prohibit enrollment in the school. Further, refusal to submit a drug test or any attempts to tamper with the specimen shall constitute ineligibility for enrollment.

**If you wish to discuss any part of this policy or would like to view the complete drug screening policy please contact the DA Program Manager.**

**I have read and understand the above:**

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**Name (please print)**

**Date**

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**Signature**

## PROGRAM REQUIREMENTS

Success as a Dental assisting student depends on many variables. Among them are academic ability and certain technical abilities or competencies. Most Dental assisting positions involve standing for long hours and performing activities that require mobility.

**MINIMUM ACCEPTABLE MENTAL & PHYSICAL COMPETENCIES** – the competencies listed below represent the **minimum** abilities necessary to successfully complete course and program objectives. The inability to meet these competencies may interfere with meeting course and program objectives and, therefore, may result in termination from the program.

1. Carry out procedures that prevent the spread of infection (*examples:* frequent hand washing, using mask and gloves, create and maintain sterile fields, etc.);
2. Lift and transfer patients, with appropriate assistance if needed, up to 6 inches from a stooped position, then push or pull the patient up to 3 feet;
3. Lift and transfer patients, with appropriate assistance if needed, from a stooped to an upright position to accomplish bed-to-chair and chair-to-bed transfers;
4. Physically apply adequate pressure to effectively control bleeding, or perform CPR;
5. Respond and react immediately to instruction/requests, monitor equipment, and perform auscultation (*example:* listen to a patient's heart sounds through a stethoscope and respond immediately to any noted problems);
6. Satisfactorily complete clinical laboratory experiences up to and including eight hours in length;
7. Demonstrate ability to effectively perform a variety of Dental assisting tasks involving observation of objects and persons, depth and color perception, and paperwork;
8. Tactilely discriminate between sharp/dull and hot/cold;
9. Perform mathematical calculation for medication preparation and administration;
10. Communicate effectively and appropriately, both orally and in writing;
11. Make appropriate decisions in a timely manner when stressful situations arise;
12. Demonstrate ability to effectively perform Dental assisting tasks using a variety of equipment.
13. Interpreting physician orders and carrying them out under provider supervision.

Applicants are responsible for: determining their own eligibility in light of these competencies. Students with disabilities who enter the program do so with the understanding they will be expected to meet course requirements, with reasonable accommodation that may be provided. All students are required to successfully complete all competencies that are required for graduation.

Requests for reasonable accommodation will be evaluated by the faculty as they arise throughout the program. The Dental assisting faculty may request a meeting with a student with a disability if concerns arise regarding the student's ability to provide safe and effective patient care.

**Your signature will indicate that you have read and understand.**

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(Signature of Applicant)

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(Date)

APOLLO ACADEMY OF MEDICAL CAREERS  
DRUG SCREENING POLICY

Students enrolled in any Apollo Career Center Health Careers Program may be required to test negative for a 9 or 10 panel urine drug screening test prior to entering clinical practice environments. All test results, positive or negative, will be sent to the appropriate program manager. In the event of a diluted or positive result, students will not be permitted into the clinical setting. **Costs for the testing will be the responsibility of the student.**

In the event of a diluted or positive test result the student may refute the results by:

1. Providing the appropriate program manager verification of prescribed medications that may result in a positive result
2. Retest at student's own expense; and provide the results of the second test, whether negative or positive to the appropriate program manager.

If the second result is negative and not diluted, the student will be permitted in the clinical setting and as long as this meets institutional policy.

Students testing positive on the second test:

1. Will not be permitted into the clinical practice environments and may be dismissed from the program as per specific program policies.
2. The student may re-apply for admission into a program but must first provide appropriate documentation from a certified drug/alcohol counselor indicating the students' readiness to reapply to Health Careers Program along with prognosis for a full recovery.

Any instructor or manager of a Health Careers Program may request a drug screen given reasonable cause. If in the clinical setting, the clinical instructors will follow that institution's policy.

**Note:** Any student seeking admission into a Health Career Program who knowingly and intentionally attempts to provide a diluted or substitute urine specimen for testing will automatically lose their eligibility to be admitted into class or put on the roster.

Any current student enrolled in a Health Careers Program who knowingly and intentionally attempts to provide a diluted or substitute urine specimen for testing will be subject to disciplinary action which may include dismissal from the program.



*Apollo Career Center – Academy of Medical Careers*  
*3325 Shawnee Road, Lima, OH 45806-1497*  
**Instructions for Application— Dental Assisting Program**

1. Print or type the information requested on the application, including reading, signing, and dating in the areas requested on the second page of the application.
  2. Read, sign, and date the enclosed copy of the Admission Policy. Read, sign, and date the release on the second page of the admission policy.
  3. Return the completed application and admission policy along with the \$30 application fee to Apollo Career Center, Dental Assisting Program, 3325 Shawnee Road, Lima, OH 45806-1497.
  4. **Complete the following step that applies to you:**

<ol style="list-style-type: none"><li>a. If you are a high school graduate, complete the form, “Request for High School Transcript” and submit it with any required fee to your high school for them to mail to Apollo School of Dental Assisting</li><li>b. If you have a GED diploma, complete the transcript form from the Ohio Department of Education and submit it with the required fee to the appropriate agency. You can go online to find the form: <a href="https://ged.com">https://ged.com</a></li><li>c. If you obtained a GED in another state, request a transcript from the appropriate agency or see website above. Your GED must be mailed from the state office to our office to be official.</li><li>d. If you are currently in high school, complete the “Request for High School Transcript” for a current transcript</li></ol>
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  5. Complete the top portion on the one (1) work reference for your current or most current employer and the two (2) personal reference forms from persons NOT related to you. Address four (4) envelopes to Apollo Career Center, Dental Assisting Program, 3325 Shawnee Road, Lima, OH 45806-1497. Place the proper postage on each envelope. Give the reference form and envelope to the appropriate reference person. **THESE REFERENCES MUST BE MAILED TO APOLLO DIRECTLY FROM THE REFERENCE PERSON.** References will NOT be accepted from the applicant. The applicant does NOT have the right to review these confidential materials.
  6. Once your application, transcripts, and references have been received Apollo will sign you up for the pre-entrance test (WorkKeys).
  7. Applicants must take one Dental Assisting Entrance Test: Work Keys Assessment Test. Areas of testing are ACT WorkKeys Applied Math, Graphic Literacy, and Workplace Documents. If the applicant is unsuccessful with the test after two attempts, documentation of successful remedial work must be submitted from your instructor to our office before the third and final test can be scheduled.
- Criteria for Being Scheduled for the DA Entrance Test:**  
When ALL of the following items have been submitted to Apollo, you will be notified of a test date:  
Application + Application fee (\$30)  
Official High School Transcript or Transcript of Equivalency  
2 **Positive** Personal References  
1 **Positive** Work Reference  
1 Signed copy of Admission Policy (a copy will be retained to you.)  
**Applicants who miss the pre-entrance test when scheduled, must call to reschedule. Entrance tests are only given once a month. Applications are held for up to 3 years from date of receipt. If your file is placed inactive, you would call to reactivate your file within those three years.**
8. Apollo will contact you regarding an interview following successful pre-entrance testing.

Applicant: please fill out information and give to high school and SCHOOL needs to MAIL this to:  
**Apollo Career Center    Dental Assisting    3325 Shawnee Road    Lima, OH 45806-1454**

## Request for High School Transcript

Please send an official transcript to:

Apollo Career Center  
Dental Assisting  
Attention: Joy Mendez  
3325 Shawnee Road  
Lima, OH 45806-1497

For:

Applicant's Name \_\_\_\_\_

Year of Graduation \_\_\_\_\_

Name at Time of Graduation \_\_\_\_\_

School from which graduated: \_\_\_\_\_

Last 4 digits of your social security number: \_\_\_\_\_

Birthday: \_\_\_\_\_

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Phone #)

\_\_\_\_\_  
(Date)

**Apollo Career Center – Academy of Medical Careers**  
**Apollo School of Dental Assisting**  
3325 Shawnee Road  
Lima, OH 45806-1497

**WORK REFERENCE**

I, \_\_\_\_\_, give my permission to the business/institution/person identified below  
*(Applicant name printed here)*  
as a work reference to provide information to Apollo Career Center. I further realize that any information will remain confidential between the school and the party giving the information.

Signature: \_\_\_\_\_ Date \_\_\_\_\_  
*(Applicant signs here)*

Name of Business/Institution: \_\_\_\_\_

Mailing Address \_\_\_\_\_

.....  
The above mention person has identified the above business or institution as a work reference. We would appreciate your assistance in helping us determine acceptability for the Dental assisting program.

Employed as \_\_\_\_\_ from \_\_\_\_\_ to \_\_\_\_\_  
*(position)*

Reason for leaving (if not presently employed) \_\_\_\_\_

Personal appearance: \_\_\_\_\_

Work Attitudes: \_\_\_\_\_

Physical & Emotional health: \_\_\_\_\_

Punctuality & Reliability: \_\_\_\_\_

If given the opportunity, would you re-hire this individual?      YES      NO

Comments:

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

Position: \_\_\_\_\_ Phone #: \_\_\_\_\_

**Apollo Career Center – Academy of Medical Careers**  
**Apollo School of Dental Assisting**  
 3325 Shawnee Road  
 Lima, OH 45806-1497

**PERSONAL REFERENCE**

I, \_\_\_\_\_, give my permission to the person identified below  
*(Applicant name printed here)*  
 to provide information to Apollo Career Center. I further realize that any information will remain confidential between the school and the party giving the information.

Signature: \_\_\_\_\_ Date \_\_\_\_\_  
*(Applicant signs here)*

Name of Personal Reference: \_\_\_\_\_

Address \_\_\_\_\_  
 (Number / Street / PO Box/ or RR) (City) (State) (Zip)

.....  
 The following information will be used to determine acceptability for the Dental assisting program. Your assistance is appreciated.

How would you rate the individual on the following traits?

	<b>Excellent</b>	<b>Good</b>	<b>Fair</b>	<b>Poor</b>
Cooperation				
Tact				
Dependable				
Punctual				
Honesty				
Integrity				
Initiative				
Perseverance				
Tolerance				
Poise				
Character				

Does he/she like to work with people?      YES              NO

How long have you known this person? \_\_\_\_\_

In what capacity have you known this person? \_\_\_\_\_

Additional Comments:

Signature: \_\_\_\_\_ Phone #: \_\_\_\_\_ Date \_\_\_\_\_

**Apollo Career Center – Academy of Medical Careers**  
**Apollo School of Dental Assisting**  
 3325 Shawnee Road  
 Lima, OH 45806-1497

**PERSONAL REFERENCE**

I, \_\_\_\_\_, give my permission to the person identified below  
*(Applicant name printed here)*  
 to provide information to Apollo Career Center. I further realize that any information will remain confidential between the school and the party giving the information.

Signature: \_\_\_\_\_ Date \_\_\_\_\_  
*(Applicant signs here)*

Name of Personal Reference: \_\_\_\_\_

Address \_\_\_\_\_  
 (Number / Street / PO Box/ or RR) (City) (State) (Zip)

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 The following information will be used to determine acceptability for the Dental assisting program. Your assistance is appreciated.

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	<b>Excellent</b>	<b>Good</b>	<b>Fair</b>	<b>Poor</b>
Cooperation				
Tact				
Dependable				
Punctual				
Honesty				
Integrity				
Initiative				
Perseverance				
Tolerance				
Poise				
Character				

Does he/she like to work with people?      YES              NO

How long have you known this person? \_\_\_\_\_

In what capacity have you known this person? \_\_\_\_\_

Additional Comments:

Signature: \_\_\_\_\_ Phone #: \_\_\_\_\_ Date \_\_\_\_\_