South East Idaho
Dental Assisting

Dental Assisting Application

Applicant Information

Full Name: _____ DOB: _____
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Phone: _____ Email _____

Education

High School: _____ Address: _____

From: _____ To: _____ Did you graduate? YES ☐ NO ☐ Diploma: _____

College: _____ Address: _____

From: _____ To: _____ Did you graduate? YES ☐ NO ☐ Degree: _____

References

Please list three professional references.

Full Name: _____ Relationship: _____

Company: _____ Phone: _____

Address: _____

Full Name: _____ Relationship: _____

Company: _____ Phone: _____

Address: _____

Employment

Company: _____ Phone: _____

Address: _____ Supervisor: _____

Job Title: _____ Starting Salary:**$** _____ Ending Salary:**$** _____

Responsibilities: _____

From: _____ To: _____ Reason for Leaving: _____

May we contact your previous supervisor for a reference? YES ☐ NO ☐

I certify that my answers are true and complete to the best of my knowledge.

If this application leads to admission, I understand that false or misleading information in my application or interview may result in my release.

Signature: _____ Date: _____

"I understand that SEIDA is registered with the State Board of Education in accordance with Section 33-2403, Idaho Code. I also understand that the State Board of Education has not accredited or endorsed any course of study being offered by SEIDA and that these courses may not be accepted for transfer into any Idaho public postsecondary institution."

Signature: _____ Date: _____