

Application valid for August 2012 Only

Date received \_\_\_\_\_  
Initials \_\_\_\_\_

**CHARLOTTE TECHNICAL CENTER**  
**18150 Murdock Circle**  
**Port Charlotte, FL 33948-3399**  
**Phone: (941) 255-7500 www.CharlotteTechCenter.com**

**DENTAL ASSISTING**  
**APPLICATION FOR ADMISSION**

Give careful consideration to each question and complete all questions on this form.  
**An incomplete application will not be accepted.**

**Please print or type**

Name: \_\_\_\_\_  
Last First Middle

Home address: \_\_\_\_\_  
Number and Street

\_\_\_\_\_ City State Zip

Phone Number: \_\_\_\_\_ Cell Phone \_\_\_\_\_

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

Date of birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Florida Residency for the last 12 months Yes \_\_\_\_\_ No \_\_\_\_\_

**EDUCATIONAL DATA**

High School \_\_\_\_\_  
Name

\_\_\_\_\_ Address City State Zip

Last Grade Completed \_\_\_\_\_ Date \_\_\_\_\_ Graduation Date \_\_\_\_\_

G.E.D. Number \_\_\_\_\_ State \_\_\_\_\_ Date Received \_\_\_\_\_

College Attended \_\_\_\_\_ Major \_\_\_\_\_

Name  
Degree Completed: Yes \_\_\_\_\_ No \_\_\_\_\_ Degree Awarded: \_\_\_\_\_

List any specialized training related to Health Occupations \_\_\_\_\_

List any other health related educational activities that do not fit in categories above? \_\_\_\_\_

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

**HEALTH RESPONSIBILITIES**

In the Health Occupations program you will be required to perform physical activities (heavy lifting, bending, standing long periods of time) and deal with highly stressful situations. To the best of your knowledge do you have any physical or emotional limitations/characteristics that could hamper you from performing these activities?

Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please explain \_\_\_\_\_  
\_\_\_\_\_

List any medicines or treatments you are taking at the present time \_\_\_\_\_  
\_\_\_\_\_

**LEGAL INFORMATION**

Have you ever been arrested, regardless of adjudication, for any offense? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, give date of arrest, charges and disposition of the case: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Licensing/Certification criteria may require that you submit court records at the completion of the program. The Board of Nursing reserves the right to deny licensure to any applicant who falsifies an application or has certain arrests.

I, \_\_\_\_\_, certify that all information contained herein is true, and understand that misrepresentation or omission of facts is cause for denial of admission or dismissal from the program.

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

\* If you hold a medical license, a copy must be submitted with this application as well as documentation reflecting the school attended and number of hours of instruction toward that license.