

YOUNGSTOWN CITY SCHOOLS  
**CHOFFIN SCHOOL OF ACCREDITED ADULT DENTAL ASSISTING  
 APPLICATION FOR ADMISSION**

<b>For Office Use Only</b>
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The Adult Dental Assisting Program provides admission to all qualified applicants regardless of race, color, religion, sex, national origin, age, ancestry or disability which does not interfere with attainment of program objectives.

**PLEASE PRINT:**

Date \_\_\_\_\_

Name \_\_\_\_\_ Phone ( ) \_\_\_\_\_  
(Last Name) (First Name) (Middle Name) (Area Code) (Number)

Address \_\_\_\_\_  
(Number & Street complete address) (City) (State) (Zip)

Social Security Number \_\_\_\_\_

**PERSON TO BE NOTIFIED IN CASE OF EMERGENCY:**

Name \_\_\_\_\_ Phone ( ) \_\_\_\_\_  
(Last Name) (First Name) (Middle Name) (Area Code) (Number)

Address \_\_\_\_\_  
(Number & Street complete address) (City) (State) (Zip)

Relationship \_\_\_\_\_

Circle only highest number of school years completed: High School 9 10 11 12 Graduate Yes  No  G.E.D. year obtained \_\_\_\_\_ College 1 2 3 4

COMPLETE NAME OF SCHOOL Last High School Attended	School Address (Number, Street, City, State)	Date (Year) Entered	Date (Year) Graduated	Date (Year) Withdrew
	Street Number			
College or Other Education	City, State, Zip Code			
	Street Number			
Major	City, State, Zip Code			

Grade average in high school?  A  B  C  D

School attendance:  Good  Average  Poor If poor, explain \_\_\_\_\_

List most recent employer first. State work experience (please include Company Name and Supervisor with proper mailing address)

NAME OF EMPLOYER	ADDRESS (Number, Street, City, State)	Type of Work	Dates	Reason for Leaving

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TEST DATE _____	PASSED _____	FAILED _____	PROVISIONAL ENTRY _____	DEFICIENT AREA _____
INTERVIEW DATE _____	ACCEPTED _____	WAITING LIST _____	NOT ACCEPTED _____	
INTERVIEW AND TESTING POINTS TOTAL _____				

Have you ever been convicted of a felony? \_\_\_Yes \_\_\_No. If yes, give full details on a separate sheet of paper and submit it along with your application.

1. How did you hear about the Adult Dental Assisting Program? \_\_\_\_\_

2. Why do you want to become a Dental Assistant? \_\_\_\_\_

3. Have you previously applied to other health profession schools? \_\_\_\_\_

4. If yes, list school(s) and year(s) attended and reason for leaving.

Name of school \_\_\_\_\_

Address of school \_\_\_\_\_  
Street City State Zip Code

Reason for leaving \_\_\_\_\_

5. Do you have any relatives in the dental profession? \_\_\_\_\_

6. What is your greatest strength? \_\_\_\_\_

7. What is your greatest weakness? \_\_\_\_\_

8. What do you feel has been your biggest accomplishment? \_\_\_\_\_

Please read the following statement and sign.

I understand that making application for admission to Choffin School of Accredited Dental Assisting does not obligate me or the School in regard to my admission to the School. I further understand that my application is to be submitted to the Admissions Committee for review, and if I am accepted I will be notified by Choffin School of Accredited Dental Assisting Department.

I further understand that any false information will void this application and will result in immediate dismissal if accepted into the program.

\_\_\_\_\_  
(Applicant's Signature)

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

**APPLICATION MUST BE SIGNED** - Application will not be considered for admission unless this statement has been read and signed by the applicant.