COLLEGE OF SOUTHERN IDAHO

DEPT. OF HEALTH SCIENCES AND HUMAN SERVICES
315 Falls Avenue • P.O. Box 1238 • Twin Falls, Idaho 83303
(208) 733-9554, Ext. 6701 • Fax: (208) 736-4743
(800) 680-0274 (in Idaho and Nevada)
TDD (208) 734-9929 Web Site: http://www.csi.edu

Application for Admission to Dental Assisting Program

Name _____
FIRST MIDDLE LAST FORMER NAME

Home Address _____
STREET ADDRESS CITY STATE COUNTY ZIP CODE

Permanent Address *(if different from above)* _____

Social Security Number _____ Home Phone: ( ) _____
AREA CODE

Business Phone: ( ) _____ ☐ Male ☐ Female
AREA CODE

EDUCATION

Official Transcript(s) MUST BE RECEIVED by the Office of Admissions and Records and a copy must be received by the Chairman of Health Science and Human Services

NAME OF SCHOOL	LOCATION OF SCHOOL	FROM MONTH / YEAR	TO MONTH / YEAR	DID YOU RECEIVE DIPLOMA? DEGREE? CERTIFICATE?	WHAT WAS YOUR MAJOR / MINOR?
HIGH SCHOOL OR GED					N/A
COLLEGE OR UNIVERSITY					

	TYPE	ISSUED BY WHICH STATE OR AGENCY	LICENSE NO.	DATE
Professional Licenses				
or Certific tion				

FOLLOW UP INFORMATION

It is important that we follow up our students to be sure they obtain appropriate employment. Please provide information about two people who will always know where to locate you.

	NAME	MAILING ADDRESS	TELEPHONE NO.
1			
2			

HEALTH RELATED WORK EXPERIENCE AND/OR VOLUNTEER EXPERIENCE

Employer _____ Phone No. _____ Ext. _____

Address _____
STREET ADDRESS CITY STATE ZIP CODE

Supervisor's Name _____ Title _____

Dates Employed: From _____ To _____ Nature of Your Job Duties _____

Reason for Leaving _____ ☐ Full ☐ P art-time

Employer _____ Phone No. _____ Ext. _____

Address _____
STREET ADDRESS CITY STATE ZIP CODE

Supervisor's Name _____ Title _____

Dates Employed: From _____ To _____ Nature of Your Job Duties _____

Reason for Leaving _____ ☐ Full ☐ P art-time

REQUEST FOR REFERENCES — (THREE REQUIRED)

Student must contact these people to send letter of reference directly to director of program. DO NOT LIST PERSONAL FRIENDS OR RELATIVES. Use names of employers, counselors or teachers. Complete mailing address required on all three names.

1	NAME	ADDRESS	PHONE
	OCCUPATION		EXT.
2	NAME	ADDRESS	PHONE
	OCCUPATION		EXT.
3	NAME	ADDRESS	PHONE
	OCCUPATION		EXT.

PLEASE READ AND SIGN THE FOLLOWING

I hereby certify that the infor mation contained in this application is true and complete to the best of my kno wledge. I understand that any misinterpretation or falsif cation of information is cause f or denial of admission or e xpulsion from the College. I understand that illegal use, possession, and/or misuse of drugs are reasons for immedia te dismissal from any of the programs in the Health Science and Human Services Depar tment.

_____ _____
SIGNATURE OF APPLICANT DATE

IN CASE OF EMERGENCY, NOTIFY:

Name _____ Phone _____

Street Address _____ City _____ State _____ Zip _____