



Employee Registration

Dentist Hygienist Assistant Front Office
(Please check appropriate box)

NAME: _____ DATE: _____

ADDRESS: _____ MAIN PHONE: _____ HM CL

CITY: _____ STATE: _____ ZIP: _____ ALT. PHONE: _____ HM CL

DATE OF BIRTH: _____ SOCIAL SECURITY NUMBER: _____

EMAIL ADDRESS: _____ REFERRED BY: _____

EMERGENCY CONTACT: _____ RELATIONSHIP: _____ PHONE: _____

SEEKING PERMANENT EMPLOYMENT: YES/ NO AVAILABLE DAYS: _____

SEEKING TEMPORARY SITUATIONS: YES/ NO AVAILABLE DAYS: _____

AVAILABLE START DATE: _____ YEARS OF EXPERIENCE IN A DENTAL OFFICE: _____

GEOGRAPHICAL AREAS WILLING TO WORK: _____

DENTAL SCHOOL (& LOCATION) ATTENDED: _____ MO/YR GRADUATED: _____

EXPOSURE TO HEPATITIS B VIRUS (HBV) AND HUMAN IMMUNODEFICIENCY VIRUS (HIV):
I am aware that working in a dental clinical setting, where blood borne pathogens exist, puts me at risk to the above viruses. I have received the HBV vaccination.

YEAR OF HEPATITIS B (HBV) SERIES: _____ WHERE GIVEN: _____
-OR-
I have not received the HBV vaccination and realize the risks. SIGNATURE: _____

I have received OSHA Safety Instruction and am aware of the chemical hazards present in dental offices.

DATE OF OSHA TRAINING: _____ GIVEN BY: _____

DENTAL SOFTWARE YOU HAVE EXPERIENCE WITH: _____

FLUENT LANGUAGES YOU SPEAK OTHER THAN ENGLISH: _____

COMMENTS: _____

I declare that, to the best of my knowledge, the above information is true and accurate.

SIGNATURE: _____ DATE: _____

OFFICE USE ONLY

AM OK? _____ UNTIL 10PM OK? _____
