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## INSTRUCTIONS TO REGISTER

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### STEP 1

EMAIL THE FOLLOWING DOCUMENTS **(MUST be received no later than a week before scheduled clinical class)**

1. Completed and signed Registration Form *(Please hand sign)*
2. Copy of 8-Hour Infection Control Certificate
3. Copy of current CPR/BLS Card through the American Heart Association or the American Red Cross
4. Documentation of proof of six (6) months experience in dental assisting in the United States OR proof of graduation from a dental assisting program OR proof of current enrollment in a dental assisting program
5. Email all above documents to: [ocdacertification@gmail.com](mailto:ocdacertification@gmail.com)
6. Make a payment.

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### STEP 2

1. Upon receipt of your completed **registration form/required documents** and **payment**, you will get an email from [ocdacertification@gmail.com](mailto:ocdacertification@gmail.com).
2. Read and respond immediately to the email that you received it.
3. You will then receive an email (during normal business hours) from OCDA/TalentLMS with your log-in information for the online course. If you do not receive an email from OCDA/Talent LMS, please check your spam folder.
4. You are ready to start your online portion of the course. Good Luck!

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### STEP 3

1. Student must complete the on-line training and quizzes before you can start the clinical class.



# ORANGE COUNTY DENTAL INSTITUTE

1076 E. 1<sup>st</sup> St. Suite D Tustin CA 92780  
 Email: ocdacertification@gmail.com  
 Website: www.orangecountydentalassistant.com

## REGISTRATION FORM

### California Radiation Safety Certification - Program 2

- **Program 2 is for the student that has little or no experience in Dental Intra-oral Radiography (require assistance on completing an FMX on a dental manikin) AND/OR needs to have more than 1 clinical patient treated at Orange County Dental Institute for completion of their required full-mouth X-rays (FMX).**

Full Name (How you want to appear on the certificate)		Date of Birth	SSN (Last 4 digits)	
Street Address	Suite# / Apartment #	City	State	Zip code
Cell Phone		Home Phone		
Student's Personal Email Address ( <b>COMPANY EMAIL ADDRESS NOT ACCEPTED</b> )				
Requested Clinical Class Date				

#### CLASS DESCRIPTION

- The program length is a maximum of 2 days or 16 hours, commensurate to your ability.
- On-line and In-class lectures: Students will learn theory and clinical skills relating to Radiation Safety.

#### REQUIREMENTS

- Student must provide four (4) clinical patients and produce two (2) FMX on each clinical patient.

#### PREREQUISITES

- **Student must be able to communicate in English**
- **Student must be 18 years of age or older.**
- Student must have 8-Hour Infection Control Certificate
- Student must have a current CPR/BLS card (AHA or ARC)
- Must have proof of (6) six months experience in dental assisting in the United States
- OR Proof of enrollment in a dental assisting program
- OR Proof of graduation from a dental assisting program

DOCUMENTATION OF PROOF: *For (6) six months experience*

- Letter written on Dental Office letterhead (including address and phone number)
- Letter to include: Dates of employment and experience
- Letter must be signed and dated by the supervising Dentist.

DOCUMENTATION OF PROOF: *For Enrollment in a Dental Assisting Program*

- Letter on Dental Assisting Program letterhead validating enrollment.

DOCUMENTATION OF PROOF: *For Graduation from Dental Assisting Program*

- Copy of Graduation Certificate

\*Note: Orange County Dental Institute will be kindly verifying your employment and experience.

REQUIREMENTS FOR CLINICAL/LAB DAY

1. Student must wear scrubs.
2. Student must wear closed toe shoes.
3. Student must have their hair pulled back above collar.
4. Student must present a valid form of identification (for example: Driver's license, Passport, CA identification, etc.)
- 5. Student must have COMPLETED the on-line learning and quizzes before class.**
6. There will be a proctored final exam once the student has completed ALL of the online material and passes the online final.
7. A certificate will be issued upon completion of the final clinical day.

PATIENT REQUIREMENTS

- Must be at least 18 years or older
  - Must have no more than 6 missing teeth and at least 26 of their natural teeth present.
  - Must have no history of cardiovascular or kidney problem.
  - Must not be pregnant.
  - Must not be in any orthodontic appliances (including permanent or fixed retainers).
  - Must complete all the necessary forms at or before time of FMX.
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## CLINICAL CLASS POLICY

- The class will start at the scheduled time. Out of respect for other students please be ready to start. If student arrives 15 minutes late from the start time of class, the student will be required to reschedule to another date for the clinical/laboratory portion of the course.  
[REDACTED] (Initial here that you understand)
- If student does not pass written final exam on clinical day, student will be allowed ONE retake of written final exam WITHIN 15 days of completed clinical course.  
[REDACTED] (Initial here that you understand)
- Retake exam will be scheduled on a day and time determined by the instructor and WILL NOT be on a clinical instruction day. [REDACTED] (Initial here that you understand)
- IF STUDENT FAILS THE FINAL EXAM ON THE RETAKE ATTEMPT, STUDENT UNDERSTANDS THAT HE/SHE FORFEITS REGISTRATION FEE AND WILL NEED TO REPURCHASE THE COURSE AND START OVER.  
[REDACTED] (Initial here that you understand)

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## REGISTRATION POLICY

**Registration and payment MUST be received no later than a week before scheduled clinical class.** Registrations received after normal business hours (9am – 6pm Monday to Friday, excluding holidays) will be processed the following business day. Please allow up to 1-2 business days to process your registration. Once registration and payment are processed, you will receive an e-mail from [ocdacertification@gmail.com](mailto:ocdacertification@gmail.com) with details on how to start the online portion of the course. Please check your spam or bulk mail for the e-mail and attachments or you can e-mail us to follow up.

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## METHOD OF PAYMENT

**\*\*MUST CHOOSE ONE AND COMPLETE ALL HIGHLIGHTED AREAS  
BEFORE OR AFTER MAKING PAYMENT\*\***

Please check one of the following:

**Credit Card – Phone Payment**

- I authorize ORANGE COUNTY DENTAL INSTITUTE to charge the credit card starting with [REDACTED] (first 4 digits of the card) and ending with [REDACTED] (last 4 digits of the card). This payment authorization is for the goods/services described on this registration form, for the amount of \$545 only, and is valid for one (1) time use only. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company; so long as the transaction corresponds to the terms indicated in this form.

Name on Card: [REDACTED]

Card Holder Signature: [REDACTED] Date: [REDACTED]

**Credit Card – Online Payment**

- I authorize ORANGE COUNTY DENTAL INSTITUTE to charge the credit card in the web form starting with [REDACTED] (first 4 digits of the card) and ending with [REDACTED] (last 4 digits of the card). This payment authorization is for the goods/services described on this registration form, for the amount of \$545 only, and is valid for one (1) time use only. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company; so long as the transaction corresponds to the terms indicated in this form.

Name on Card: [REDACTED]

Card Holder Signature: [REDACTED] Date: [REDACTED]

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**REFUND POLICY**

- If the student does not attend his/her class, the registration fee will be automatically forfeited.
- We withhold \$280 for those who request a refund **without** written request 14 days prior to the start date.
- A full refund of \$545 is issued if the class is canceled.
- Student agrees to **complete** course within **30 days** of payment for the course or student forfeits tuition for the course. [REDACTED] (Initial here that you understand)
- **I UNDERSTAND THAT IF I DO NOT PASS THIS PROGRAM, I WILL NOT BE ISSUED A REFUND.**

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Student Signature: [REDACTED] Date: [REDACTED]