INSTRUCTIONS TO REGISTER

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
6. Make a payment.

STEP 2

1. Upon receipt of your completed **registration form/required documents** and **payment**, you will get an email from 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!

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. 1st St. Suite D Tustin CA 92780
Tel: (855)665-4200
Email: ocdacertification@gmail.com
Website: www.orangecountydentalassistant.com

REGISTRATION FORM

California Radiation Safety Certification - Program 1

- **Program 1 is intended for students already trained in Dental Intra-Oral Radiography.**
- **Students MUST be able to take an FMX (5 or less errors) unassisted on a dental manikin at start of clinical class.**

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 **(COMPANY EMAIL ADDRESS NOT ACCEPTED)**			
Requested Clinical Class Date			

CLASS DESCRIPTION

- On-line and In-class lectures: Student will learn theory and clinical skills relating to Radiation Safety.

REQUIREMENTS

- Each student must provide (4) four clinical patients and produce (1) one FMX on each clinical patient. (FMX = 18 images per patient that includes 4 BWX's)
- One (1) FMX on each of (3) three clinical patients will be taken by the student at their present facility before the first day of class.
- The (3) FMX's must be validated by the supervising dentist that the FMX's were completed by the student (see attached form).
- The (3) three validated FMX's taken at your facility must be given to the instructor at the beginning of the clinical class.
- The 4th patient will be treated for an FMX in class on the clinical day.

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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***

- A letter written on Dental Office letterhead (including address and phone number)
- Letter to include Dates of employment and experience.
- The 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 bring their three (3) completed full mouth x-rays(**MUST be saved on a USB drive/THUMB drive/Flash Drive in a FMX layout and MUST be on a JPEG or PDF format)** along with the Validation Form signed by the supervising dentist.
6. **Student must have COMPLETED the on-line learning and quizzes before class.**
7. There will be a proctored final exam once the student has completed ALL of the online material and passes the online final.
8. A certificate will be issued upon completion of the 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 retainer).
- Must complete all the necessary forms at or before the time of FMX.

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.
  _____ (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.
  _____ (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. _____ (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.
  _____ (Initial here that you understand)

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 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.

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 _____ (first 4 digits of the card) and ending with _____ (last 4 digits of the card). This payment authorization is for the goods/services described on this registration form, for the amount of $410 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: _____

  Card Holder Signature: _____ Date: _____

☐ **Credit Card – Online Payment**

- I authorize ORANGE COUNTY DENTAL INSTITUTE to charge the credit card in the web form starting with _____ (first 4 digits of the card) and ending with _____ (last 4 digits of the card). This payment authorization is for the goods/services described on this registration form, for the amount of $410 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: _____

  Card Holder Signature: _____ Date: _____

REFUND POLICY

- If the student does not attend his/her class, the registration fee will be automatically forfeited.
- We withhold $205 for those who request a refund **without** a written request 14 days prior to the start date.
- A full refund of $410 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. _____ (Initial here that you understand)
- **I UNDERSTAND THAT IF I DO NOT PASS THIS PROGRAM, I WILL NOT BE ISSUED A REFUND.**

Student Signature: _____ Date: _____

VALIDATION FORM

To be completed by Supervising Dentist

Agreement made this (day)_____of (month) _____, (year)_____

Between **Thomas Boone, DDS** and **DR** _____
(Director of Orange County Dental Institute)

The validity of this agreement and any terms or provisions, as well as the rights and the duties of the party hereunder, shall be governed by the laws of the State of California. The three patients listed below had full mouth radiographic series, a minimum total of (18) images including (4) bitewings completed at my dental facility under my **direct clinical supervision.**

Student Name: _____ produced these (3) FMX's and can mount correctly, expose and process radiographs (either manually or automatically) traditionally with film or digitally with complete competence. The student was given sufficient time to complete this clinical task. The radiographic operatory must full comply with California Radiation Control Regulations (Title 17 California Code Regulations, commencing with section 30100), and is properly equipped with supplies and equipment. Radiographic machines must be adequately filtered and collimated in accordance with Department of Health services regulations and are equipped with the appropriate position-indicating devices for each technique utilized. All aspects of x-ray quality, examinations, procedures and radiation safety must be in accordance with Section 106975 of the Health and Safety Code.

- **Radiographic series produced with analogue (film) MUST utilize traditional (2) film packets.**
- **All Digital series MUST be saved on a flash drive or emailed in an FMX LAYOUT as either JPEG or PDF FILES.**

1. Patients Name (Please Print)	Date of Exposure
2. Patients Name (Please Print)	Date of Exposure
3. Patients Name (Please Print)	Date of Exposure

Dentist Name (Please Print)	Dentist's California License Number	
Address	City	Zip Code
Phone		

Licensed Dentist Signature: _____ Date: _____

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