

PLEASE TYPE OR PRINT CLEARLY

# Dental Hygiene Program Application ( Due April 15, 2009)

**Portland Community College**

Date: \_\_\_\_\_  Applied last year (2008)  Alternate last year

**Identifying Information**

PCC ID: G \_\_\_\_\_ and/or SSN: \_\_\_ - \_\_\_ - \_\_\_\_

Name: \_\_\_\_\_  
*Last First Middle Initial Maiden*

Home Address: \_\_\_\_\_  
\_\_\_\_\_

Day Phone: \_\_\_\_\_ Evening Phone: \_\_\_\_\_ Message Phone: \_\_\_\_\_

Email: \_\_\_\_\_ (Do not list if you don't check it weekly)

**In case of emergency, please notify:**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Day Phone: \_\_\_\_\_ Evening Phone: \_\_\_\_\_

**Education**

GED: \_\_\_\_\_  
*Where Year Score*

High School: \_\_\_\_\_  
*Name City State Year*

College/University	Years	Degrees	Semester or Quarter system	*
_____	_____	_____	<input type="checkbox"/> S <input type="checkbox"/> Q	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/> S <input type="checkbox"/> Q	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/> S <input type="checkbox"/> Q	<input type="checkbox"/>

\*check box if official transcripts have already been submitted to PCC; to confirm call Student Records Dept 503-614-7100

**Demographic Data:** Portland Community College is committed to affirmative action goals and would appreciate your response to the following:

Ethnic Group (please check only one)

- Black, African American, Non Hispanic
- American Indian/Alaskan Native
- Asian/Pacific Islander
- Hispanic
- Other \_\_\_\_\_

Birthdate: \_\_\_\_\_  
Month / Day / Year

Gender (check one)

- White
- Multiracial
- Prefer not to answer

- Male
- Female

The Dental Hygiene program is a closed entry program with limited enrollment. Please be advised that completing prerequisites and applying to the program does not guarantee admission.

**All required documentation is the full responsibility of the applicant.  
Failure to provide all required documentation invalidates your application.**

**Accepted students must provide the following prior to the first day of class:**

- Copy of Current Health Care Provider CPR Certification (Class must include Adult, Child, Infant CPR and Use of Defibrillator)
- Evidence of completion of Hepatitis B Vaccination Series (or signed declination form), Measles Mumps Rubella and Chicken Pox vaccination (or history of past disease), current Tetanus (within last 10 years), current Tuberculin skin test (within last year).

**Accepted students must:**

- Pass a criminal history check prior to practicum and/or field training as a condition of their acceptance into a medical, dental, or community facility.
- Follow all OSHA, CDC and State regulations regarding blood borne and infectious diseases. Refer to the Dental Hygiene section in the PCC Catalog or [www.pcc.edu/dh](http://www.pcc.edu/dh) website for the program policy regarding applications with infectious disease. Specific PCC Infection Control Policies and Procedures are available upon request to applications.

# DENTAL HYGIENE APPLICATION

PCC ID: G and/or SSN:      -      -     

## Prerequisite Course Completion Record

Applicants wishing to substitute a course for a PCC requirement must supply a printed course description from the college where the course was taken with the application for approval. The description must be from the year the class was taken.

**Please check this box if you wish for your points to be calculated after winter term grades:**

At PCC:  At another college, which I will provide transcripts by 4/15:

**English Composition (Writing 121)** Course Name: \_\_\_\_\_ Institution \_\_\_\_\_

**Introductory Algebra (Math 65 or higher)** Course Name: \_\_\_\_\_ Institution \_\_\_\_\_

**Anat & Phys. I with lab (BI 121 or 231)** Course Name: \_\_\_\_\_ Institution \_\_\_\_\_

**Anat & Phys. II with lab (BI 122 or 232)** Course Name: \_\_\_\_\_ Institution \_\_\_\_\_

**Microbiology with lab (BI 234)\*** Course Name: \_\_\_\_\_ Institution \_\_\_\_\_

\*must be completed within 7 years (2002 or later)

**Organic Chemistry with lab (CH 102 or 106)** Course Name: \_\_\_\_\_ Institution \_\_\_\_\_

## **Support Courses/Experience:**

Speech: Institution \_\_\_\_\_ Term/Year \_\_\_\_\_

Psychology: Institution \_\_\_\_\_ Term/Year \_\_\_\_\_

Sociology: Institution \_\_\_\_\_ Term/Year \_\_\_\_\_

Nutrition: Institution \_\_\_\_\_ Term/Year \_\_\_\_\_

**Experience:** must be documented on company letterhead from a supervisor listing length of experience, job title and duties. Experience points are given for one of the following:

- 1) CDA or work experience in a dental setting (minimum 1 year experience)
- 2) Health Careers Course (year-long H.S. course)
- 3) Job Shadow of a practicing Dental Hygienist (minimum 20 hours)

## **Supplemental Questions**

On a separate sheet(s) of paper, **submit a typed** response to the following questions. Both content and presentation will be assessed. Accurate and detailed responses are expected.

**Identify your name & PCC ID or Social Sec. # on each page.**

1. List special skills, experience, or education that will enable you to be successful in this program. Describe how you have benefited from these or other activities or volunteerism.
2. Describe your long-range professional goals (5 years from now).

**Applications are only accepted from January 1st through April 15th at 5pm.**

All application materials must be received in the Dental Department by 5pm, on April 15th.

Late Applications and/or Postmarked dates of April 15<sup>th</sup> WILL NOT be accepted.

If you are sending materials via U.S.P.S. please allow 7 business days for shipping

**Required application materials to be included with completed application:**

- Official sealed transcripts from Colleges and/or Universities, other than PCC.  
\*International transcripts must be evaluated by a PCC authorized evaluation company and submitted to the Health Admissions Office as an official document, in a sealed envelope.
- Non-refundable application fee, in the amount of \$25.00, made payable to PCC Dental Hygiene Program.
- Documentation of Experience (as noted on reverse side)
- Self-addressed & stamped 3x5 post card to be returned to applicant upon receipt of application.

**The Dental Department, SY HT 206**

**Send all application materials to:**

**Portland Community College**

**PO Box 19000 Portland, OR 97280-0990**

**NOTE:** If you have further questions or would like advising, call or email us at: 503-977-4795

I certify that the information I have provided is accurate. I understand that if it is found otherwise, my application will be invalid. I certify that I have included all the required application materials listed above and understand that if I have not, my application will be invalid. I understand that Portland Community College is not responsible for notifying me of any missing materials prior to the application deadline.

Applicant Signature: \_\_\_\_\_ Date: \_\_\_\_\_