



**STATE
TECHNICAL
COLLEGE**
OF MISSOURI

State Technical College
Dental Assisting Technology
One Technology Drive
Linn, MO 65051
Phone 573-897-5000 FAX 573-897-5026
www.statetechmo.edu

Applicant Observation/Information Form

Student Name _____

Address _____

City _____ State _____ Zip _____

Name of Dentist Office or Dental Practice _____

Dentist/Dental Asst. Name _____

Email _____

Work Address _____

City _____ State _____ Zip _____

Phone Number: Work _____ Fax: _____

Dates and Times of Observation _____

Dentist / Dental Asst. Signature _____

Students considering a career in dental assisting, make more informed career decisions if their choices are based on personal experiences or observations. If you have never worked in a dental office, it is required that students observe a **minimum** of 4 hours in the office of your general dentist or a local general dentist.

For credit towards admission, students must document their experience by taking this form with them to the dentist office. Students should call and make an appointment with the dentist office regarding an observation time. Ask the person you are observing to sign the form in the designated area. **Students are required to have a signed Statement of Confidentiality signed by the dentist that you will observe before your observation begins.**

Professional dress is a must when observing at the clinical sites. Jeans, t-shirts, sweatshirts, or tennis shoes are **not** allowed. No pierced jewelry shall be worn with the exception of one earring per earlobe. Overall appearance should be clean and neat. A professional appearance inspires confidence in the patient.

On an additional piece of paper please type or print your observation experience. Describe the examinations and equipment that you observed.

Students Signature _____



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Statement of Confidentiality

Healthcare providers are required by law, to maintain patient confidentiality

Before you can job shadow in a dental office, you must understand that you too are responsible for treating information about patients and patient records with utmost confidentiality. Following your job shadowing experience, you **MUST NOT** talk about patients who were seen in the office during your observation time or about anything that pertains to the treatment of a patient. All patients and patient care information must be kept confidential.

This form must be taken to your selected job shadowing site and signed by you and the dentist **before** you begin your clinical observation. This signed **Statement of Confidentiality** must be returned with your Applicant Observation Form.

I understand that it is my responsibility to respect the confidentiality of the patients and the patient/office records, to follow office procedures in order to protect patient privacy and to act in a professional manner. I further understand that if I am found acting indiscreetly with confidential material or not protecting the privacy of a patient or others through my actions, I will be dismissed from the observation site immediately. Notification of my dismissal will be made to the Program Director. I recognize that this action is necessary in order to maintain high professional standards and integrity of the site in which I observe.

Please review this form and any observation location rules with the dentist, a copy of this form should be maintained at the observation location.

Students Signature _____

Dentist/Dental Rep. _____