Dental Assistant/Radiology

Application & Registration Form

541.880.2243| ce@klamathcc.edu

Program Mission:

Students will be eligible to take the DANB (Dental Assisting National Board) Radiation Health and Safety certification exam. Students will be able to earn a non-credit training certificate from Klamath Community College.

Students will learn basic dental assistance to prepare for future dental certifications and the dental radiology exam after obtaining verification from an Oregon-licensed Dentist or Dental Hygienist within six months of being authorized to take radiographs.

Course Description:

This 20-week course has six hours of classroom instruction per week for a total of 140 hours. In addition, each student will be required to complete a 70-hour Internship with a local Dentist and KCC instructor at Klamath Health Partnership to shadow and practice providing patient dental care.

Participation and attendance are mandatory to be placed in an internship. You are allowed two absences during this program, which you should save for illness and emergencies that prevent you from attending class.

This course has a student cap of 8 students. Students will be entered into the program on a first-come, first-served basis.

Prerequisites & Program requirements:

- High school graduate or GED equivalent
- Must be 18 years or older before class starts.
- Up to date on all vaccinations (Provide copy)
- Hepatitis B vaccine series & Tuberculin (TB) skin test (Provide copy)
- COVID-19 vaccination is required by Oregon Health Authority to participate in clinical internship.

Requirements to be completed during training:

- BLS American Heart Association card

- Completion of agreement & internship orientation with clinic prior to internship
- Completion of 70- hour internship
- Pass a random Drug Screen & Background check (No refunds due to inability to pass background check/drug screen)
- Attend resume workshop

*Screening can be conducted any time prior to the start of internship. All applicants understand that inability to pass the drug screen and/or background check will affect their ability to complete internship and program requirements.

*Disclaimer: Although marijuana may be legal in the state of Oregon for adults over the age of 21, most providers do not allow it and therefore we cannot accept any student into the internship that tests positive for marijuana on their drug screen.

If you have any questions about your ability to meet these requirements, please contact the Workforce/Community Education Department Coordinator at 541-880-2243.

Course Topics:

1. Dental Assisting profession
2. Science in Dentistry
3. Oral Health and Prevention of Dental Disease
4. Infection Prevention in Dentistry
5. Occupational Health and Safety
6. Patient Information and Assessment
7. Foundation of Clinical Dentistry
8. Dental Radiography
9. Dental Materials
10. Assisting in Comprehensive Dental Care
11. Dental Administration and Communication Skills

Schedule:

Our Dental Assistant/Radiology program is offered twice a year during the Winter & Fall Term. It is three days a week, Monday, Wednesday 5pm-8pm and Friday 3pm-6pm.

Dates: 09/08/25-01/30/2026

Course Supplies:

Students will need to purchase scrubs.
All other supplies including a textbook, is provided to all student.

Application/ Registration Process:

Please scan all documents in PDF version to ce@klamathcc.edu or make an appointment tosubmit your documentation in person. If all materials are complete, you will receive a letter ofadmissions to your email with next steps.

Course Cost: $2,400
Payment is due the first week of class. This class is not eligible for financial aid. A paymentplan is available in installments of three. Please inquire with the Cashier's Office in Building9.

Student Grant Options:

- **KCC Foundation Scholarships**
  Non-credit/Apprenticeship (EAO) scholarship, Student Emergency Grant
  Contact: Lisa Carter,541-880-2234,carter@klamathcc.edu

- **STEP Program at Klamath Community College**
  Must be receiving SNAP benefits (food stamps).
  Contact: Reynda Scobee, STEP Coordinator, 541-880-2343, Scobee@klamathcc.edu

- **STEP Program at Worksource**
  Must be receiving SNAP benefits (food stamps). 30-day eligibility period
  Contact: Tangie, Lead STEP Coordinator,
  Tangie.M.MCREYNOLDS@employ.oregon.gov or visit Worksource to make an appointment.

- **Workforce Innovation Opportunity Act (WIOA) Federal Program at Worksource& Klamath Works**
  Must be receiving SNAP,TANF,SSI,Dislocated worker/displaced homemaker, or low-income. 30-day eligibility period.
  Contact: Tina Scotton, WIOA Manager, 541-891-4667, tina@klamathworks.com

- **Vocational Rehabilitation Training Funds**

  Voc. Rehab assists individuals with disabilities for job placement that matches their skills, interests, and abilities.
  Contact: Tammi 541-883-5614

Job Placement:

- A resume and cover letter class are included in this course. KCC also has a Career Center located in Building 4.They area able to provide job search assistance,resume, cover letter, and interviewing techniques.

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Name_____

(Last) (First) (Middle)

Phone Number_____

Email Address_____

Mailing Address Line 1 _____

Mailing Address Line 2 _____

City_____ **State**_____ **ZIP**_____

Date of Birth_____ **Gender** ☐ Male ☐ Female

MM/DD/YYYY

Marital Status ☐ Married ☐ Single **Ethnicity** ☐ Hispanic/Latino ☐ Not Hispanic/Latino

Race (check all that apply) ☐ African American/Black ☐ American Indian/Alaska Native ☐ Asian ☐ Pacific Islander ☐ White

Social Security Number _____

Providing your social security number is **not required for Community Education**. If you plan to take credit classes and apply for Federal Financial Aid, it will be required.

In order to receive a refund, students must fill out an Add/Drop Form. Refunds are based on the following criteria: **Students must drop prior to first class in order to receive refund.**

KCC is required to collect some of the data for institutional compliance. We appreciate your cooperation. Non-Discrimination Policy: Klamath Community College is an equal opportunity educator and employer.

Payment Options: (check one)

☐ Credit Card ☐ Enclosed Check ☐ Enclosed Cash ☐ Scholarship Name:_____

Card Number_____ Expiration Date_____

Name as it appears on card_____ CVC #_____

☐ Visa ☐ MasterCard ☐ Discover

I hereby certify that I have provided complete and accurate information on this form, and I understand that if it is found to be otherwise, it is sufficient cause for rejection or dismissal. Signature also confirms payment.

_____

Student Printed Name Student Signature Date

KLAMATH Community College

HEPATITIS B VACCINATION
HEALTH PROFESSION
STUDENTS

HEPATITIS B VIRUS (HBV) causes a viral infection, which involves the liver. The spectrum of disease ranges from asymptomatic infection to fulminant disease, which may lead to death. Six to ten percent of infected young adults become carriers of the infection. Over 25 percent of these carriers develop chronic active Hepatitis, which often progresses to cirrhosis. There has been an association demonstrated between the Hepatitis B carrier state and the occurrence of liver cancer. The disease is spread by introducing infected blood or body fluids into the body by percutaneous or per mucosal routes, i.e. sharps injury, getting infected blood or body fluids into non-intact skin or on mucous membranes, and by sexual contact and intravenous drug use. There is evidence that there is increased risk of HBV infection for health care workers who have frequent contact with blood and body fluids. In addition, more virulent form of Hepatitis is associated with superinfection or coinfection by Delta virus. Delta virus can only infect and cause illness in persons with Hepatitis B infection. Therefore, persons immune to HBV infection are also immune to Delta virus infection.

HEPATITIS B VACCINE immunizes against infection caused by all known subtypes of HBV. It is a vaccine prepared from cultures of a recombinant strain of yeast Saccharomyces cerevisiae. The vaccine contains thimerosal (a mercury derivative) and as preservative.

INDICATIONS FOR USE: Hepatitis B vaccine is indicated for persons at increased risk for developing HBV infection and who are demonstrated to be susceptible to HBV. Risk is based on frequency of contact with blood or body fluids.
Healthcare workers without occupational exposure to blood or body fluids are at no greater risk of infection then the general population.

PRIMARY ADULT VACCINATION consists of a series of three intramuscular injections of one ml. each. The first dose is given at the selected date. The second and third doses follow the first by one and six months, respectively.
Administration of doses at longer intervals may be equally protective but optimal protection is not achieved until after the third dose. Vaccination of carriers will not cause harmful or beneficial effects.

ANTIBODY TESTING prior to receiving Hepatitis B vaccine is recommended to determine the immune status of the individual. Post-vaccine antibody testing is also recommended to determine immunity induced by the vaccine.

REVACCINATION NONRESPONDERS: When persons who do not respond to the primary vaccine series a revaccinated, 15%-25% produce an adequate antibody response after one additional dose and30%-50% after three additional doses.

BOOSTER DOSES for adults with normal immune status, booster doses of vaccine are not recommended, nor is routine serologic testing to assess antibody status after the primary post-vaccine antibody screening.

SIDE EFFECTS consist mostly of pain at the injection site (3%-29%) and a slight fever (1% to 6%).

PRECAUTIONS: Persons with hypersensitivity or allergic reaction to yeast or any other vaccine components should not begiven recombinant Hepatitis B vaccine. Neither pregnancy nor lactation should be considered a contraindication to vaccination.

__I received the Hepatitis B vaccination series in the past at

_____(facility)on

_____(Approximate date)

Student Signature_____Date: _____

Date Site Given by

1.

_____

2.

_____

3.

_____

KLAMATH
Community College

HIPPA CONFIDENTIALITY STATEMENT

I understand that during my clinical rotations I may have access to confidential information about clients, patients, their families and clinical facilities. I understand that I must maintain confidentiality of all verbal, written or electronic information and in some instances, the information may be protected by law, such as state practice acts or other regulatory standards. In addition, the client's right to privacy by judiciously protecting information of a confidential nature is part of the health professionals expected behavior.

Through this understanding and relationship to professional trust, I agree to discuss confidential information only in the clinical setting as it pertains to patient care and not where visitors and/or other patients may overhear it.

During each clinical rotation in the education program, I agree to follow each agency's established procedure on maintaining confidentiality.

_____ _____

STUDENT SIGNATURE DATE

_____

PRINTED NAME

KLAMATH
Community College

WAIVER OF LIABILITY AND INFORMED CONSENT

As a participant in the Klamath Community College (KCC) Dental Assistant/Radiology Program, I have read, understand, and agree to the following:

- I willingly consent to participate in all laboratory treatments and practicesessions as a human subject (i.e. patient) for educational purposes at KlamathCommunity College. These treatments may be rendered by faculty or byfellow students.
- As a participant in a phlebotomy training program, I may be exposed to avariety of hazards and risks of injury, foreseen or unforeseen. While properindustry safety procedures will be discussed in the program, KlamathCommunity College and its program partners cannot eliminate the potentialfor such injuries. Furthermore, **it is my responsibility to disclose anyinformation or medical issues that will limit or bar me from the aboveparticipation to the instructor in a timely manner.**
- I agree that I am personally responsible for all risks associated withparticipation in the KCC Dental Assistant/Radiology Program. To the fullestextent allowed by law, I agree to waive, release, discharge, and hold harmless Klamath Community College, its Board of Education, and all of its officers, agents,employees, and representatives from any and all liability, claims, causes ofaction, or demands arising out of any injuries to me or my property whichmay result from my participation in the KCC Phlebotomy Program.
- I willingly consent to appear in photographs, transparencies, films,videotapes, and other forms of media, for educational and informational purposes at Klamath Community College.
- I willing consent to give the Health Science Program Director or Klamath Community College Designee permission to give my Student IdentificationNumber and other personal information to the Klamath Community Collegeclinical affiliations and licensure/registration authorities for appropriatereasons. I willingly consent to give the Community Education Departmentpermission to release drug testing results, or Criminal Offender RecordInformation (CORI) to clinic sites that may require such information as termsof their contract with Klamath Community College for clinical affiliations.

_____ _____

STUDENT SIGNATURE DATE

_____

PRINTED NAME

KLAMATH Community College
Workforce & Community Education

MEDIA RELEASE

I,_____, **authorize** KCC, and any additional agencies (*indicated here*) _____to use my image, likeness, or name in media releases, promotional displays, on websites or on other printed or graphic materials.

I,_____, **do NOT authorize** KCC, and any additional agencies to use my image, likeness, or name in media releases, promotional displays, on websites or on other printed or graphic materials.

_____ _____

STUDENT SIGNATURE DATE

_____

PRINTED NAME

FERPA Consent to Release Student Information

Founders Hall · Building 9 · 7390 South Sixth Street · Klamath Falls, OR 97603

KLAMATH Community College

Last Name _____ First Name _____ Student ID Number _____

It is the policy of Klamath Community College, in accordance with the Family Education Rights and Privacy Act (FERPA), to withhold personally identifiable information contained in our students' education records unless the student has consented to disclosure. Private information, such as grades, class schedules, the student's account, and financial aid awards may not be released without express consent from the student. Signing this form provides such consent, according to the information designated for release and to whom it is to be released.

I, _____, authorize Klamath Community College to release the following educational records, upon request, to the persons listed below, for the purpose of keeping them informed regarding my education at Klamath Community College.

Please initial all that apply:

_____All financial records in the Business Office

_____All Financial Aid Information

_____All academic records in the Registrar Office

_____All medical/ disability documents in Student Support Services

_____Other: _____

_____Other: _____

Persons to whom information can be released:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

All listed persons will have access to the initialed information/ departments above. If a person shall have access to different information than listed, student must complete a separate form for said person.

Please provide the contact information for the previously stated persons to whom information can be released.

Name: Mailing Address: Phone Number: ( ) Email:	Name: Mailing Address: Phone Number: ( ) Email:
Name: Mailing Address: Phone Number: ( ) Email:	Name: Mailing Address: Phone Number: ( ) Email:

I acknowledge by my signature that I understand that, although I am not required to release my records, I am giving my consent to release the designated information to the above named person(s). I understand that this release will remain in effect unless I revoke such consent in writing and the revocation is received and processed by Klamath Community College.

_____ _____

Student Signature Date

Return to Enrollment Services

Received By: Date: