

# PASCO-HERNANDO COMMUNITY COLLEGE DIVISION OF HEALTH PROGRAMS

## CERTIFICATE IN DENTAL ASSISTING APPLICATION

Once you have met all of the program requirements for admission as listed on the application information page, you may submit this application to the Admissions and Student Records Office, West Campus/New Port Richey. Prior to submitting this limited access application to the Admissions Office, pay the non-refundable \$25 application fee at any PHCC College Store.

Name: \_\_\_\_\_  
Last
First
Middle (required)

Previous Names: \_\_\_\_\_

Student ID Number: \_\_\_\_\_

Address: \_\_\_\_\_  
Street  
 \_\_\_\_\_  
City
State
Zip

Phone Numbers: ( ) \_\_\_\_\_ ( ) \_\_\_\_\_ ( ) \_\_\_\_\_  
Home
Work
Other

***Applicant certification:*** I certify that all statements given in this application are true and accurate to the best of my knowledge. Any falsified information may result in my dismissal from the program. I have read and submitted the information on the enclosed checklist regarding application requirements, prerequisites, and other requirements concerning the dental assisting program at PHCC.

\_\_\_\_\_  
**SIGNATURE**
DATE

FOR OFFICE USE ONLY							
<input type="checkbox"/> Checked by _____	<table style="width: 100%; border: none;"> <tr> <td style="width: 50%;">Date _____</td> <td style="width: 50%;">\$ _____</td> </tr> <tr> <td><input type="checkbox"/> Cash Receipt</td> <td>No. _____</td> </tr> <tr> <td><input type="checkbox"/> Register Invoice</td> <td>Cashier _____</td> </tr> </table>	Date _____	\$ _____	<input type="checkbox"/> Cash Receipt	No. _____	<input type="checkbox"/> Register Invoice	Cashier _____
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Dental Assisting - May