



Dental Auxiliary Service - Austin

P.O. Box 153116 Austin TX 78715 512-243-5736

EMPLOYMENT APPLICATION

PERSONAL INFORMATION

Date: _____

Name _____ Social Security Number _____ - _____ - _____

Present Address _____
Address City State Zip

Phone # (_____) _____ Cell Phone # (_____) _____

Email _____ What foreign languages do you speak? _____

Referred to DAS by _____

In case of emergency notify _____
Name Address Phone #

EMPLOYMENT DESIRED

Position _____ Part Time _____ Full Time _____ Temporary _____

Are you currently employed? _____ What days are you available to work? _____

Date you can start _____ Salary Desired _____

How do you feel about working with children? _____

PHYSICAL RECORD

Condition of your health _____ Date of last physical exam _____

Condition of your teeth _____ Date of last dental exam _____

Have any impairments in your hearing? _____ in vision? _____ in speech? _____ dexterity? _____

back problems? _____ Any disease of the lung? _____ Do you smoke? _____

Have you had any major surgery, illness, or been hospitalized? _____

Nature of condition _____

SKILLS ASSESSMENT

Please rate each skill on a basis of 1-10 (10 being the highest) as it relates to your strength in each skill

SKILLS	STRENGTH
Appointment book management	
Past due collections	
Completing insurance claims	
Following up claims with insurance companies	
Appointment confirmations	
Presenting treatment plans	
Presenting financial arrangements	
Handling apprehensive patients	
Dental Software (specify program(s): _____)	
Handling irate patients	
Balancing daily financial data	
Preparing statements	
Filling short notice cancellations	
Presenting a good image for the office	
Telephone skills	
Screening calls/sales people for dentist	
Asking patient for payment at time of visit	
Computer experience	
General dental assisting skills	
Current infection control procedures	
Typing _____ WPM	
Handling recall	
Dental terminology	
Calculating ratio of production/collections/overhead	
Patient rapport	
Composing letters to patients, dentist, etc.	

Additional skills and ratings not listed above: _____

I certify that all questions are fully and correctly answered, and I authorize this office to contact all former employers and other persons necessary to verify the facts and information that I have furnished in reference to my qualifications and experience. I understand that giving false or incomplete information could be considered misconduct and could lead to termination. I authorize this office to do background checks. I hereby release any employer, personnel agency, its agents and other persons from any and all liability of whatever nature regarding any facts and all information obtained in reference to my qualifications, background, and experience.

Signature of applicant _____

Date _____

ACKNOWLEDGEMENT

I have received a copy of the Dental Auxiliary Service – Austin, Inc. Employee Handbook and have read and understood its contents. I understand that the handbook is intended to provide an overview of the Company’s personnel policies and does not necessarily represent all such policies in force. The Company may at any time, in writing, add, change or rescind any policy or practice at its sole discretion, without notice.

In addition, I have received HIPAA, OSHA, and HB300 information and have read and understood its contents. I understand that the information is intended to provide an overview of HIPAA, OSHA, and HB300 information and does not represent all such information in force.

I understand that employment and compensation are for not fixed term and may be terminated by the Company at any time with or without cause or notice. Likewise, I may resign at any time. I further understand and agree that no person other than the Manager of the Inc. has the authority to enter into written or oral agreement different than what is stated herein.

I have been notified that Dental Auxiliary Service – Austin, Inc. has elected not to obtain workers’ compensation insurance coverage.

Employee Name (Please Print)

Date

Employee Signature

Supervisor Name (Please Print)

Date

Supervisor Signature

HEPATITIS B STATUS
For the office of Dental Auxiliary Service – Austin, Inc.

Date: _____ / _____ / _____

Name of Applicant: _____

Please complete **ONE** of these categories (**exact dates are not required; months and years will suffice**):

I. I **have completed** the following in the HBV Series:

Initial Injection Date _____ / _____ / _____

Second Injection Date _____ / _____ / _____

Third Injection Date _____ / _____ / _____

II. I **have scheduled** the following in the HBV Series:

Initial Injection Date _____ / _____ / _____

Second Injection Date _____ / _____ / _____

Third Injection Date _____ / _____ / _____

I understand that due to my occupational exposure to blood and other potentially infectious materials, I am at risk of acquiring Hepatitis B Virus (HBV) infection. I understand the possible effects of this disease; that being acute and chronic illness, becoming a chronic carrier, cirrhosis, and that is associated with a higher risk for liver cancer. I understand there is no effective treatment or cure for Hepatitis B. I understand that the Hepatitis B Vaccine has been reported to be 85-96% effective in providing protection from Hepatitis B, when the three-dose series has been administered as recommended

Signature

Date

I understand by not receiving this vaccine, I continue to be at risk of acquiring Hepatitis B, a serious disease. If, in the future, I continue to have occupational exposure to blood or other potentially infectious materials, I release Dental Auxiliary Service - Austin, Inc. from all liability for any exposure or contamination related to temporary or permanent employment at the aforementioned company.

Signature

Date

Reference Verification Form

Applicant – please complete ONLY THE TOP HALF of this form with the contact information of the selected office. We will submit the form and request the bottom portion be completed.

TO BE COMPLETED BY APPLICANT (*REQUIRED FIELDS)

- * Office Name: _____
- * Supervising Dentist/Direct Supervisor: _____
- City/State: _____
- * Office Phone: _____ * Office Fax: _____
- *Email Address: _____
- * Name while working at the office: _____
- * Position Held // Approximate Dates Worked: _____
- * Reason for Leaving: _____

I hereby authorize you to issue to DENTAL AUXILIARY SERVICE – AUSTIN, INC any information you may have regarding my skills and character and to hereby unconditionally release you from all liability for any damage whatsoever which may result from furnishing same.

SIGNATURE: _____ DATE: _____

****APPLICANT STOP COMPLETING FORM HERE****

EMPLOYER: The applicant mentioned herein has made application with our agency for assistance in securing employment in the dental profession. Your verification of employment will be appreciated. Only appropriate information will be shared with any potential employer.

TO BE COMPLETED BY FORMER EMPLOYER

I rate the above name former employee as the following:

	EXCELLENT	GOOD	FAIR	POOR	COMMENTS
Attendance	_____	_____	_____	_____	_____
Motivation	_____	_____	_____	_____	_____
Neatness	_____	_____	_____	_____	_____
Organization	_____	_____	_____	_____	_____
Skills	_____	_____	_____	_____	_____
Patient Rapport	_____	_____	_____	_____	_____
Team Effort	_____	_____	_____	_____	_____

Is this employee eligible for rehire? YES _____ NO _____ Remarks: _____

PRINT NAME: _____ POSITION: _____

EMPLOYER'S SIGNATURE: _____ DATE: _____

Dental Auxiliary Service – Austin, Inc.

Authorization for Direct Deposit – Employee Form

This authorizes **Dental Auxiliary Service – Austin Inc.** (the “Company”) to send credit entries (and appropriate debit and adjustment entries), electronically or by any other commercially accepted method, to my (our) account indicated below and to other accounts I (we) identify in the future (the “Accounts”). This authorizes the financial institution holding the Account to post all such entries.

Account Information

Account Type: **Checking** **Savings** **PayCard**

Employee Bank Name

Bank Routing # (ABA#)

Account #

This authorization will be in effect until the Company receives a written termination notice from myself and has a reasonable opportunity to act on it.

Printed Name

Signature

Date

Please include a voided check to be attached to this form.