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
Routine scaling	
Deep scaling_______________currette____________________ultrasonic _________________	
Soft tissue programs (specify:____)	
Perio probing and charting: manual___________computer__________________PSR ______________	
Use of antimicrobial agents for subgingival irrigation	
Patient education	
Patient rapport	
Explaining treatment needs (operative, surgical, etc.)	
Working with children	
Working with elderly	
Taking, developing, mounting x-rays: bite-wings_________FMX_____________Panographic _______________	
Sealants	
Updating health histories and other record keeping	
New patient exam charting	
Assisting with recall (as schedule permits)	
Being responsible for recall	
Assisting other staff members (dental assistant/business assistant)	
Working in two operatories with an assistant	
Knowledge of OSHA 2002 Bloodborne Pathogens Standards	
Use of Rotodent, Sonicare, and similar products for home care	
Use of Prophy Jet	
Dental terminology	
Working in a specialty: Perio________Pedo_____________Ortho ____________	
Presenting treatment plans	

Right handed_____________Left handed _____________

Additional skills/knowledge 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

Dental Auxiliary Service – Austin, Inc.

P.O. Box 153116 Austin TX 78715
Phone: 512-243-5736 Fax: 512-682-7516

Reference Verification Form

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

<u>TO BE COMPLETED BY APPLICANT (*REQUIRED FIELDS)</u>

* 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

<u>EMPLOYER:</u> 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.

<u>TO BE COMPLETED BY FORMER EMPLOYER</u>

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: ______________

<u>Dental Auxiliary Service – Austin, Inc.</u>

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 <u>voided</u> check to be attached to this form.