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 & 1 being lowest), as it relates to your strength in each skill.

SKILLS	STRENGTH
Routine scaling	
Deep scaling_____Curette_____Ultrasonic _____	
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	
Working with an accelerated schedule (45-50min prophies; multiple columns)	
Taking, developing, mounting x-rays: Bite-wings_____FMX_____PANO _____	
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	

Dexterity: Right-handed | Left-handed | Ambidextrous

Are you N2O monitoring certified? No | Yes (if yes, please provide documentation)

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 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 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 understand that job information given to me by DAS is strictly confidential whether it is for a temporary job assignment, job interview, or working interview. Sharing this information with anyone by any means, directly or indirectly, including social media, is considered a breach of confidentiality that we guarantee our clients during their applicant search and can be grounds for disciplinary action up to, and including, termination.

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. 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.