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 ____

DDS SKILLS/EXPERIENCE LEVEL

Rate yourself as to your abilities in the areas listed below:

**** 0 – No experience 1 – Very Little Experience, Training Need 2 – Average 3 – Above Average ****

Scaling/Root Planing ______________
Extractions – Simple ______________
Extractions – 3rds/Impacted ______________
Crown and Bridge ______________
Removable Prosthodontics ______________
Endo – Anterior ______________
Endo – Posterior ______________
Implants ______________
N2O Sedation ______________
Oral Sedation ______________
IV Sedation ______________
Pedodontics ______________
Orthodontics ______________
Periodontics ______________
Bleaching/Whitening ______________
Veneers ______________
Composite Fillings ______________
Onlays/Inlays ______________
Digital X-Rays ______________
Dental Software ** ______________
** ______________________

Current Texas License # ______________
Expiration Date ______________
National Provider ID # ______________

Do you have current liability ______________

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 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 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</u>

***Required fields**

To the office of*: ____________________
Address: ____________________
City, State, Zip: ____________________
Office Phone*: ____________________ Office Fax*: ____________________
Email address*: ____________________

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.

Name Used: ____________________
Position Held: ____________________
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: ____________________

<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					
Organization					
Time Management					
Skill Level					
Patient Rapport					
Team/Staff Rapport					
Team Management					

Is this employee eligible for rehire? YES __________ NO__________ Remarks ____________________

____

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