SCHOOL OF DENTAL MEDICINE
CASE WESTERN RESERVE UNIVERSITY

EXPANDED FUNCTION DENTAL AUXILIARY PROGRAM

APPLICATION FOR ADMISSION

Application Checklist

_____ Application fee $40.00

_____ ***Official*** transcripts from your high school or college identified by ***seal*** of issuing institution

_____ Documentation of your current status as an auxiliary, i.e. ***notarized copy*** of your hygiene license or current CDA certificate, or a copy of your application to sit for the DANB OR CODA exam

_____ Letters of recommendation from two persons (other than your dentist-employer).

_____ Letter of verification for 2 years in general dentistry within past 5 years as a chairside assistant

_____ Hepatitis B vaccination documentation or proof of current titer if vaccine documentation cannot be provided OR if it has been 10 years or longer since vaccination

_____ Current TB test (PPD) documentation (yearly test)

_____ Copy of dental assisting school diploma (if applicable)

_____ Completed Employer Recommendation Form

_____ Completion of Program Performance Requirements

_____ Completion of Employer / Remote Site Sponsor

_____ Completion of Personal Statement

_____ *Foreign trained dentists:
*Educational Credential Evaluation Documentation (ECE)
*TOEFL Examination Documentation

Name: _____

APPLICATION FOR ADMISSION

Please complete application and return with your **application fee of $40**.

Name (Last) (First) (Middle) (Maiden)

Address (Street) (City) (State) (Zip)

( ) - ( ) -

Residence Phone Cell Phone Email Address

Social Security # Date of Birth Years in Dentistry Latex Allergy? Gender

Are you a citizen of USA? ☐ Yes ☐ No

If not, please list which county: _____ **Visa:** _____

Ethnicity

Are you Hispanic or Latino? ☐ Yes ☐ No

If you wish to be identified with a particular ethnic group, please check all that apply:

- ☐ African American, African, Black
- ☐ Native American, Alaska Native
- ☐ Asian American (country): _____
- ☐ Asian, incl. Indian Subcontinent (country): _____
- ☐ Hispanic, Latino (country): _____
- ☐ Mexican American, Chicano
- ☐ Puerto Rican
- ☐ Native Hawaiian, Pacific Islander
- ☐ White or Caucasian
- ☐ Other (specify): _____

Training

Where did you receive your dental assisting or hygiene training? _____

Right or left handed (for seating purposes)? _____

Preferred class time: ☐ Wednesday ☐ Friday ☐ Flexible

(Day cannot be guaranteed due to space limitations)

CDA _____ RDH _____ Foreign-trained Dentist _____

Employer Info

Employer-dentist

Address (Street) (City) (State) (Zip)

( ) -

Business phone

Educational Record

School	Check highest level completed	Name of School and Location	Degree	Year Graduated
High	1 2 3 4 ☐☐☐☐			
Vocational	1 2 3 4 ☐☐☐☐			
College/ University	1 2 3 4 ☐☐☐☐			
Other	1 2 3 4 ☐☐☐☐			

Dental Employment Experience

Name of Employer	Mailing Address	Date of Employment	
		From mm/dd/yy	To mm/dd/yy

Please send the following to Case Western Reserve School of Dental Medicine:

1. ***Official*** transcripts from your high school or college identified by ***seal*** of issuing institution.
2. Documentation of your current status as an auxiliary: ***Notarized copy*** of your hygiene license **or** current CDA certificate (or a copy of your application to sit for the DANB OR CODA exam).
3. **Foreign Trained Dentist**: (ECE) Educational credential evaluation AND TOEFL examination documentation.
4. Letters of recommendation (signed) from two persons (other than your dentist-employer).
5. Letter of verification for 2 years of experience in general dentistry within past 5 years as a chairside assistant.
6. Hepatitis B vaccination documentation **or titer** if HepBVac 10 years or older.
7. Current TB test (PPD within past year) documentation
8. Copy of Dental Assisting school diploma (if applicable).
9. Completed Employer Recommendation Form
10. Completion of Employer / Remote Site Sponsor
11. Completion of personal statement

Prior to action on this application, all materials must be received by Case Western Reserve University School of Dental Medicine ***along with*** this form and a nonrefundable $40 application fee. *This fee is not applicable to tuition.

Send to:
Case Western Reserve University
School of Dental Medicine
EFDA Program
10900 Euclid Avenue
Cleveland, OH 44106-4905

*Please make check payable to:
Case Western Reserve University-EFDA Program

I HEREBY CERTIFY THAT THE STATEMENTS I HAVE MADE HEREIN ARE TRUE. ANY FALSE INFORMATION MAY LEAD TO DISMISSAL FROM THE PROGRAM.

Signature (applicant MUST sign) Date

Personal Statement (attach additional page, if necessary)

In the space below, please indicate:

1. Why you would like to become an EFDA?
2. Your knowledge of EFDA duties (in Ohio).
3. Your willingness and ability to spend the necessary time, outside class, to complete required reading and studying.
4. How you plan to use your EFDA training once you become certified.

Case Western Reserve University School of Dental Medicine
Expanded Functions Dental Auxiliary Program
Employer Recommendation Form

The purpose of this form is assist the admissions committee in selecting students applying to the CWRU EFDA Program that show evidence of the skills necessary to become an EFDA in Ohio. This information is held in strict confidence and will be used solely for making decisions about annual admittance into the EFDA Program.

Applicant's Name: Date:

Length of employment with current employer – dentist:

The following evaluation should be based on demonstrated performance compared to that reasonably expected of an auxiliary at his or her level of training, experience and background. Please mark an "X" in the appropriate box listed for each item listed:

PERFORMANCE	POOR	FAIR	GOOD	SUPERIOR	NOT OBSERVED
Basic Professional Knowledge					
Judgement					
Professional Manner and Appearance					
Technical / Hand Skills					
Following Direction					
Cooperativeness					
Punctuality / Dependability					
Communication Skills					

Current Dentist – Employer Name (printed): _____

Address: _____

Dentist Signature: _____ Phone:_____

Program Performance Requirements

All students admitted to the Expanded Function Dental Auxiliary Program must be able to meet the following requirements:

1. Students must be familiar with restorative procedures

2. Students must be able to use both direct vision and indirect mirror vision to complete and evaluate restorations, and will have to perfect fine motor skills to enable the accurate and safe application of dental handpieces and instruments.

3. Students must be familiar with basic dental terms and nomenclature.

4. Students must be able to function effectively under the time constraints of the program and display flexibility in the event of changing lab and clinical . situations.

5. Students must be able to apply didactic learning (theory) to clinical situations.

6. Students must be able to hear and communicate effectively, follow directions and act professionally in class and when delivering patient care.

7. Students must be able to read the printed words in EFDA textbooks and supplemental information, observe various dental instrument angulations and apply the concepts appropriately.

8. Student's eyesight must be able to visualize fine detail (either naturally or corrected),have depth perception and have the ability to visualize three dimensional objects.

9. Students must be physically free of the use of non-prescription drugs, illegal drugs and alcohol.

10. Students must be able to read and speak fluent English.

11. Students must show acceptable progress and pre-clinical competency in the program by a prescribed time before they are allowed to provide care to patients.

I acknowledge that I have read and understand the program performance requirements expected of me should I be accepted into the EFDA Program.

_____ _____

Signature Date

Case Western Reserve University School of Dental Medicine
Expanded Functions Dental Auxiliary Program
Employer Remote Site Participant Form

I understand that my auxiliary is applying to the CWRU EFDA Program and that if accepted, I will be expected to allow her / him to place restorations in office (amalgam, composite and pit and fissure sealants) on patients under my Direct Supervision during the second semester of the course in order to fulfill the Ohio State Dental Board required hours of patient clinical care to complete the program.

I further understand that I will receive from my auxiliary(once enrolled) information to learn about the grading criteria, discuss sections of the Ohio Revised Code and be presented a document requiring my signature indicating my office be used as a remote site facility while my auxiliary is attending the EFDA Program.

_____

(Pint name – Dentist)

_____

(Signature – Dentist) (Date)

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Clinical Site Requirement Information for the Dentist

The EFDA student will complete the basic typodont restorations that we require before permitting clinical experience in the first semester of the program. Then, in the second semester, authorization will be given for your auxiliary to begin placing Classes I, II, III, and V amalgam, Classes I, II, III, IV and V composite, and temporary restorations on selected patients under your direct supervision. Documentation of the completed restorations must be recorded in the students' grade sheets and must be evaluated immediately after placement using the grading key provided. In addition, the EFDA student may also place rubber dam (including clamp placement), pulp protection materials and pit and fissure sealants.

The dentist's responsibilities include evaluation of restorations, documentation of completed restorations, and documentation of hours accrued. The Ohio State Dental Board mandates that EFDA students accrue clinical/patient experience placing restorations. 32 hours may be given in our remote facilities on class days and the other 48 to be acquired in private practice on non class days. Any additional hours will enhance performance.

The requested hours of hands-on experience in the dental practice is a requirement necessary to allow the auxiliary to sit for the EFDA board exam administered by the Commission on Dental Testing in Ohio or the examination administered by the Commission on Dental Assessment Competencies.

SCHOOL OF DENTAL MEDICINE
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Applicant Referral Information

Whom may we thank for referring you to our program?

Name _____

Address _____

City _____ State _____ Zip Code _____

Email address _____

Phone _____