2017 Dental Candidate Packet

This packet includes the following forms:

- Chairside Assistant Form
- Medical History Form
- Post-Operative Care Agreement
- Incident Disclaimer
- Patient Consent, Disclosure & Assumption of Responsibility
- Periodontal Treatment Selection Worksheet (Optional. Use only if taking the Periodontal section)
SRTA Chairside Assistant Form

If you are using a chairside dental assistant during the SRTA Patient Treatment Clinical Examinations you must complete this form. Attach a photograph of you assistant in the two designated areas on this form. This must be presented to the Forms Desk the day of the examination; otherwise, you will not be permitted to utilize a chairside assistant.

Candidate Sequential: _______
PLACE ID LABEL HERE
Test Site: _______

Assistant Name: __________________________
Assistant Address: ________________________
Assistant Telephone: ______________________

I affirm that the person listed above will act as a chairside assistant for the examination:
Exam Site: ____________________
Candidate Sequential: _______

I further affirm that the assistant is adequately knowledgeable about infection control and dental procedures so as not to cause harm to the patient or other personnel with whom the assistant may come in contact with.

For the Restorative Procedures, I affirm that said chairside assistant is not a dentist (licensed or unlicensed), last year/senior dental student or dental laboratory technician. I understand that I may use a dental assistant, dental hygienist or first/second year dental student.

For the Periodontal Procedure, I affirm that said chairside assistant is not a dentist (licensed or unlicensed), last year/senior dental student or dental hygienist (licensed or unlicensed), final year dental hygiene student or dental laboratory technician. I understand that I may use a dental assistant or first/second year dental student.

I affirm that the chairside assistant will wear proper attire and the photo identification badge at all times while assisting me.

I understand that I am responsible for any and all actions and behavior of the chairside assistant that may violate the examination policy of the SRTA Examination.

As the chairside assistant, I affirm that I will maintain the anonymity of all candidates and examiners that I may encounter.

I understand that as a chairside assistant, I am not to enter the scoring area at any time prior to, during and following the published times of the examination.

I understand that failure to comply with any of the aforementioned articles will result in the candidates’ dismissal from and failure of the examination. Additional penalties may also include restrictions on the candidates’ ability to sit for future examinations.

By signing below, I acknowledge that all infractions will be reported to the State Boards of Dentistry.

This agreement (with the attached photo of the assistant) will be held by the Clinic Floor Coordinator on-site and will be sent to the SRTA Office when the Examination is complete.

Signature of Candidate ________________________ Date ______

Signature of Assistant ________________________ Date ______

Authorized Chairside Assistant

Place Assistant Photograph Here

SRTA
Candidate Sequential Number

Chairside Assistant Name
Date
Site
**SRTA Medical History Form**

**Patient Name:** ________________

**Birthdate:** ________________

**Weight:** ________________

**Date Form Completed:** ________________

**Candidate Seq. Number:** ________________

**Cubicle Number:** ________________

**Blood Pressure:** ________________ → **CFC Pin**

**Date/Time Taken:** ________________

**Pre-Medication?**  YES OR NO

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**INSTRUCTIONS TO PATIENT:**

Answer the following questions as completely and accurately as possible. All information is CONFIDENTIAL. Please circle “Y” for Yes or “N” for No to all questions, and write your answers as appropriate.

1. **YN** Are you under the care of a physician at this time? If yes, for what condition?

2. The name, address and telephone number of my physician is: ________________

3. My last complete physical examination was: ________________

4. **YN** Has a physician treated you in the past six months? If yes, for what condition?

5. **YN** Have you been hospitalized or have a serious illness or skin condition with the last five years?
   If yes, please specify: ________________

6. **YN** Are you allergic to or had any adverse reaction to any medicine, drugs, local anesthetics, LATEX or other substances?
   If yes, please specify: ________________

7. **YN** Do you now or have you ever smoked cigarettes or used tobacco products?
   If yes, please specify:  Number of packs/day: ________________  Number of years: ________________

8. **YN** Do you have or have you had any of the following diseases/problems? Please explain “Y” answers below.

<p>| | | |</p>
<table>
<thead>
<tr>
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<tbody>
<tr>
<td>A. <strong>YN</strong> Heart Attack</td>
<td>K. <strong>YN</strong> Congenital heart disease</td>
<td>U. <strong>YN</strong> Liver disease (hepatitis A, B or C/jaundice/cirrhosis)</td>
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<tr>
<td>Date: ________________</td>
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<tr>
<td>B. <strong>YN</strong> Heart Surgery</td>
<td>L. <strong>YN</strong> Congestive heart failure</td>
<td>V. <strong>YN</strong> Kidney/renal disease</td>
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<tr>
<td>Date: ________________</td>
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<tr>
<td>C. <strong>YN</strong> Stroke</td>
<td>M. <strong>YN</strong> Pacemaker</td>
<td>W. <strong>YN</strong> Thyroid disease</td>
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<tr>
<td>Date: ________________</td>
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<tr>
<td>D. <strong>YN</strong> Artificial/prosthetic heart valves</td>
<td>N. <strong>YN</strong> Implanted cardio-defibrillator</td>
<td>X. <strong>YN</strong> Cancer/chemo/radiation therapy</td>
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<tr>
<td>Date: ________________</td>
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<tr>
<td>E. <strong>YN</strong> Artificial/prosthetic joint replacement (knee or hip)</td>
<td>O. <strong>YN</strong> Abnormal bleeding bruise or history of transfusion. Taking aspirin or blood thinner?</td>
<td>Y. <strong>YN</strong> Sexually transmitted disease(s)</td>
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<tr>
<td>Date: ________________</td>
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<td>F. <strong>YN</strong> Arteriosclerosis/ coronary occlusion</td>
<td>P. <strong>YN</strong> Lung/respiratory condition (asthma, bronchitis, emphysema)</td>
<td>Z. <strong>YN</strong> HIV positive/AIDS</td>
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<td></td>
<td>Q. <strong>YN</strong> Tuberculosis or pertussis</td>
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<tr>
<td>G. <strong>YN</strong> Angina/chest pain, shortness of breath</td>
<td>R. <strong>YN</strong> Diabetes</td>
<td>AA. <strong>YN</strong> Immune suppression or immune deficiency</td>
</tr>
<tr>
<td>H. <strong>YN</strong> High blood pressure</td>
<td>S. <strong>YN</strong> Epilepsy/seizures/convulsions</td>
<td>BB. <strong>YN</strong> Alcohol abuse (alcohol rehabilitation)</td>
</tr>
<tr>
<td>I. <strong>YN</strong> Valve damage following heart transplant</td>
<td>T. <strong>YN</strong> Emotional/mental health disorder (anxiety, depression, bipolar)</td>
<td>CC. <strong>YN</strong> Drug abuse (cocaine, methamphetamine, heroin, crack) or drug rehabilitation</td>
</tr>
<tr>
<td>J. <strong>YN</strong> Infective endocarditis (heart infection)</td>
<td></td>
<td>DD. <strong>YN</strong> Have you been diagnosed with MRSA?</td>
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</tbody>
</table>

**EXPLANATION FOR YES ANSWERS IN QUESTION 8**

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[1]
9. **Y N** Have you had surgery or x-ray treatment for a tumor, growth or other condition of your head or neck?  
   If yes, please list:  

10. **Y N** Do you have any other diseases, conditions, or problems that have not been listed?  
    If yes, please explain:  

<table>
<thead>
<tr>
<th>OTHER CONDITION</th>
<th>EXPLANATION</th>
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11. **Y N** Are you taking or have you ever taken any medications, (examples below), either orally or by injection, for osteoporosis, osteopenia or bone loss due to aging OR lung cancer, breast cancer, prostate cancer, colorectal cancer, wet macular degeneration, Paget’s Disease, or multiple myeloma?  
   Examples: Fosamax® (alendronate); Boniva® (ibandronate); Actonel® (risedronate); Reclast® yearly injection (zoledronic acid); Aredia® ( pamidronate); Zometa® (zoledronic acid); Bonefos® (clodronate); Avastin® (bevacizumab); Erbitux® (cetuximab); Herceptin® (trastuzumab)?

12. **Y N** Please list any pre-medication, medications, pills, or drugs with dosage which you are taking both prescription and nonprescription. (Must be completed the DAY OF THE EXAMINATION)  

<table>
<thead>
<tr>
<th>MEDICATION</th>
<th>REASON PRESCRIBED</th>
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13. **WOMEN ONLY**  
   **Y N** Are you pregnant or is there any possibility that you might be pregnant? If yes, when is your expected due date?  

   **Y N** Are you currently breast feeding?  

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**AMERICAN SOCIETY OF ANESTHESIOLOGY (ASA CLASSIFICATION)**

ASA I: Normal health patient  
ASA II: Patient with mild systemic disease; no function limitation – e.g., smoker with well controlled hypertension  
ASA III: Patient with severe systemic disease; definite functional impairment – e.g., diabetes mellitus (DM) and angina pectoris with relatively stable disease, but requiring therapy

**DENTAL CANDIDATES:** Any item on the Medical History with a YES response in questions #4-13 could require a medical clearance from a licensed physician if the explanation section indicates the possibility of a significant systemic condition that could affect the patient’s suitability for elective dental treatment during the examination. The medical clearance must include the physician’s name, address, and phone number, Attach letter to this form to turn in on the day of the exam.

I certify that I have read and understand the information above. I acknowledge that I have answered these questions accurately and completely. I will not hold the testing agency responsible for any action taken or not taken because of errors I may have made when completing this form.

---

Patient Signature  

Date  

Candidate Sequential Number & Initials  

Date  

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SRTA Post-Operative Care Agreement

A separate form must be completed for each patient treated during the examination.

Candidate Information
Candidate Seq. Number: ____________________________
Examination Site: ____________________________
Examination Date: ____________________________

Procedure

□ Restorative
□ Periodontal
□ Dental Hygiene

Patient Information
Name (Print): ____________________________
Address: ____________________________
City, State, Zip Code: ____________________________

Today’s Date: ____________________________
The SRTA Examination is the process for determining if a Dentist has the minimal practical skills necessary to obtain a license to practice Dentistry; therefore, no guarantee can be made that the work performed will be adequate. If you feel you may need additional care as a result of the work performed during the examination, you should visit a licensed Dentist. You may visit a Dentist of your choosing or you may use the referral listed below. (Note to Candidate: Please complete only one of the sections – A, B, or C – listed in item I. A signature is required under Item II – Patient Acceptance.)

I. Acceptance of Responsibility for Post-Operative Care

☐ A. The patient is a “patient of record” at the Dental School and will provide post-operative care as necessary according to the guidelines of the School of Dentistry.

Signature of Authorized School Official: ____________________________
Date: ____________________________

☐ B. This is to confirm my willingness to provide any post-operative care required related to treatment rendered on the ADEX dental examination. It is understood that this agreement expires sixty days following the examination.

Name: ____________________________
License #: ____________________________
Telephone #: ____________________________
Address: ____________________________
City, State, Zip Code: ____________________________

Signature of Provider: ____________________________
Date: ____________________________

☐ C. I will choose my own Dentist if post-operative care is necessary.

Signature of Provider: ____________________________
Date: ____________________________

Reason for Post-Operative Care:

__________________________________________________________________________________________

II. Patient Acceptance – I understand and agree to the following:
   • Additional treatment related to services rendered during this examination may be required
   • Post-operative arrangements specified above
   • There may be a fee involved in the post-operative care and I hereby release ADEX and associated testing agencies, and the School of Dentistry where the examination was held from any financial obligation
   • The provider listed above has no obligation to provide care if not initiated within sixty (60) days of the examination

Patient Signature: ____________________________
Date: ____________________________
Patient Telephone #: ____________________________

Legal guardian or Parent Signature (If patient is minor): ____________________________
Date: ____________________________
CFC Pin: ____________________________

This form may be downloaded and duplicated. Submit the Original and Copy #1.
Agency - Original
Examination Site - Copy #1
Patient - Copy #2
Candidate - Copy #3
Provider - Copy #4

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INCIDENT DISCLAIMER

DISCLOSURE STATEMENT AND EXPRESS ASSUMPTION OF RISK FOR ANY DAMAGE FROM (1) EXPOSURE TO BLOODBORNE INFECTIONOUS AGENTS SUCH AS HIV, HBV, AND OTHER MICROORGANISMS IN THE BLOOD, (2) EXPOSURE TO ORAL OR RESPIRATORY SECRETIONS,(3) OTHER INJURIES.

The relationship between the Southern Regional Testing Agency (SRTA), the school where the examination is administered ('the school') and you (the candidate or patient) is not an employer/employee relationship. Neither SRTA nor the examination site is responsible for your behavior. As a candidate or patient, you do not qualify as an employee and are not covered under OSHA regulations. You must assume responsibility for any exposure or other incident which may occur.

SRTA and the school cannot, and therefore, do not assume any responsibility or liability for the health status of candidates assistants or patients. If an exposure or other injury occurs during the course of this examination, neither SRTA nor the school assumes any duty or responsibility to you to provide serologic testing, counseling, follow-up care or any other health service. It is your responsibility to assure that you see a licensed health care professional and initiate appropriate management and follow-up care.

LIMITATION OF LIABILITY AND INDEMNITY AGREEMENT

I, the undersigned, state that I have read and understood the above disclosure statement and express assumption of risk. I agree that SRTA and the school are not responsible for the prevention or management of any of the incidents listed above. I agree to release and discharge SRTA for any liability or personal injury which may occur to me, unless actively committed by SRTA. I agree to release and discharge the school for any liability or injury that may occur to me unless actively committed by school personnel. I further understand that SRTA and the school have no responsibility or duty to provide medical evaluation treatment, counseling, follow-up care, or any type of compensation for any of the incidents listed above. I also agree to indemnify and hold SRTA and the school harmless for any occurrence under this agreement, including SRTA's and the school's attorneys' fees, costs and expenses, should a claim be made against them.

Candidate: Printed Name & Candidate SEQ#

Candidate: Signature

Candidate: Date Signed

Patient: Printed Name

Patient: Signature

Patient: Date Signed
I authorize the individual referenced below (the "Candidate") to perform the following dental procedure(s) during the administration by the testing agency (SRTA) of a dental licensing examination or dental hygiene examination (the "Examination"):

- Posterior Amalgam Prep & Restoration
- Posterior Composite Prep & Restoration
- Anterior Composite Prep & Restoration
- Periodontal Treatment
- Partial Oral Prophylaxis and Periodontal Scaling - Dental Hygiene

Acknowledgement
I understand the following:
- the Candidate may not be licensed to perform the above services (the "Services"). (Cross through this line if the Candidate is a licensed dentist.)
- any arrangements between the Candidate and me regarding my serving as a patient (including any financial arrangements) are solely between the Candidate and me, and do not involve the testing agency in any way.
- the Testing Agency has no knowledge of the Candidate’s skill or competence, and makes no promises about them.
- the Testing Agency has no duty to, and will not, notify me of inadequate work done by the Candidate during the Examination.
- it is my responsibility to have any and all dental work performed by the Candidate checked by a licensed dentist to determine that it is satisfactory.
- I hereby consent to having the Candidate perform each of the Services.

Disclosure of Risks
The Candidate has explained to me the risks and possible complications involved in the procedures the Candidate will perform on me and the nature and purpose of the dental procedure(s) to my satisfaction. My questions with regard to the dental procedure(s) have been answered.

Adequacy of Treatment
I understand that the Services provided during the Examination does not necessarily fulfill all my oral health needs, may not be performed correctly, or may not represent my entire treatment plan, and that further treatment may be necessary. I have been informed of the availability of services to complete treatment.

No Treatment by SRTA or School
I understand that SRTA will not be performing any diagnosis or treatment of me. Further, I understand that all the procedures will be performed in spaces under the control of the School but that faculty members, officers, employees and agents of the school will not be present during the performance of the Services. I hereby release the School, its faculty, staff, employees and agents from any and all claims, causes of actions, demands, rights and damages whatsoever arising out of or in connection with the Services performed by the Candidate.

Authorization of Disclosure of Medical Information
I recognize that medical information which could be pertinent to the oral health care I receive in the course of the Examination may be communicated to the Testing Agency, their examiners, the staff and clinicians of the dental school where the Examination is located, and any other medical professionals when deemed medically necessary.
necessary, or when necessary for the administration for the Examination. I authorize this disclosure. This authorization specifically includes the disclosure of radiographs (X-rays), and information about my current medical and dental condition and my prior medical and dental history. I further consent to disclosure of any information concerning my medical information by SRTA, so long as my name is not associated with the information.

**Medical Condition and Medications**
I have fully disclosed my current medical conditions and medical history to the best of my knowledge and all medications I am taking. I have been informed that patients who are taking bisphosphonate medications may be at risk of osteonecrosis of the jaw after dental treatment or as a result of dental infections. I understand that neither the Testing Agency nor the school assumes any responsibility or liability regarding the health status of patients or candidates. As neither the candidate nor patient is considered an employee of the Testing Agency or school, OSHA regulations do not apply. If an exposure to blood borne agents such as HIV or hepatitis or other infectious conditions occurs, it is not the responsibility of the testing agency or school to provide serologic testing, counseling, follow up care or any other health service.

**Consent to X-Rays and Photographs**
I consent to the taking of appropriate radiographs (X-rays) and the examination of my teeth gums. I also consent to having testing agency examiners or the staff and clinicians of the dental school take photographs of my teeth and gums for use in training and future examinations, provided that my name is not in any way associated with the photographs or X-rays.

**Anesthesia**
I understand that as part of the dental procedure(s), it may be necessary to administer local anesthetics and I consent to the use of anesthetics by the Candidate.

**Assumption of Risk and Release**
I release the SRTA, participating dental schools, and their employees and/or agents from any and all responsibility or liability of any nature whatsoever for their acts, which occur during the course of this Examination, and any damages or injuries I may suffer as a result of my participation in the Examination. I hereby voluntarily assume all risks relating to the Services and the examination, including the risk of injury, loss of teeth and/or death.

I verify that I am not a dentist (licensed or unlicensed), a dental student in the 3rd or 4th or final year of dental school, or a dental hygiene student in the final year of school.

By my signature below, I verify that I have read and fully understood the above information, and I agree to the terms of this agreement.

______________________________    ____________________
Patient Signature                  Date

______________________________    ____________________
Candidate Sequential Number & Initials  Date

**NOTE:** This form will be used by examiners during the procedures. Candidates should initial, NOT sign in order to preserve anonymity.
Periodontal Treatment Selection Worksheet

By the day of the examination all information on this form must be accurately transferred electronically to the computer-based Periodontal Evaluation Form.

Do not submit this Form to the Evaluation Station, it is only for your use prior to and on the day of the examination. This Form may be duplicated as needed.

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**Subgingival Calculus Detection**

You are allowed to use only 6 to 8 teeth, but twelve surfaces must be indicated. In the box to the left, enter tooth number. Record the tooth numbers in ascending order using the 1 to 32 system. In the adjacent box, indicate the surface on the tooth where you have selected to remove the calculus (M=Mesial, F=Facial, D=Dental, L=Lingual). If more than one surface is selected on the same tooth, enter tooth number each time a new surface is listed, example:

```
3  M
3  D
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You must select one molar and at least two more molars and/or premolars. All posterior teeth must have at least one approximating tooth within 2 mm distance. No more than 4 surfaces may be selected on incisors. **At least 3 surfaces must be on interproximal surfaces of molars and/or premolars.**

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**Pocket Depth Qualification**

From the Subgingival Calculus Detection list above, select 3 separate teeth with 4 mm or deeper pockets. Enter the tooth number in the box to the left. Indicate the surface where the selected pocket is located in the adjacent box (M=Mesial, F=Facial, D=Dental, L=Lingual). It is not necessary to select one of these surfaces to scale.

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**Plaque/Stain Removal**

Enter the first 6 separate teeth from the Subgingival Calculus Detection list above. These teeth will be evaluated for the removal of plaque, stain, and supragingival calculus on the crowns of the teeth.

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*It is the candidate’s responsibility to accurately transfer the information from this Treatment Selection Worksheet to the electronic Evaluation Form prior to presenting the patient for assignment.*

*Each time the patient is sent to the Evaluation Station, the Periodontal Progress Form, Medical History, Informed Consent and radiographs must accompany the patient.*

*The Forms Desk will insert Start and Finish times on the Periodontal Progress Form upon check out.*

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