2020 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: _____

Place Assistant Photograph Here

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/third 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/third 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** _____

Cut Here Cut Here

Authorized Chairside Assistant

Place Assistant Photograph Here

SRTA

Candidate Sequential Number

Chairside Assistant Name _____

Date _____

Site _____

F O L D H E R E

SRTA

SRTA | Medical History Form

Candidate Sequential: _____
Candidate Label: _____
Test Site: _____

PLACE ID LABEL HERE

Candidate # _____	**Cubicle #** _____
Will this patient be shared with another candidate today? ☐**Yes** ☐**No**	**Sharing patient with Candidate #** _____

Patient Name _____			Date Form Completed _____
Birthdate _____	Weight _____	Blood Pressure _____ Required – must be taken day of exam	Date/Time Taken _____ CFM confirms BP taken day of examination
			CFM Pin _____

Instructions to Patient

Answer the following questions as completely and accurately as possible. All Information is CONFIDENTIAL. Please circle "YES" or "NO" to all questions and write in your answers as appropriate.

1. **YES** **NO** Are you under the care of a physician at this time?
If yes, for what condition? _____

2. The name, address & telephone of my physician is _____

_____

3. My last complete physical examination was on _____

4. **YES** **NO** Has a physician treated you in the past six months?
If yes, for what condition? _____

5. **YES** **NO** Have you been hospitalized or have a serious illness or skin condition within the last five years?
If yes, please specify: _____

6. **YES** **NO** Are you allergic or had any adverse reaction to any medicine, drugs, local anesthetics, LATEX or other substances?
If yes, please specify: _____

7. **YES** **NO** Do you now or have you ever smoked cigarettes or used tobacco products?
If yes, please specify: # of packs/day: _____ # of years: _____

8. Do you have or have you had any of the following diseases/problems? Please explain "YES" answers below. **"YES" answers in the shaded area require a written letter from the patient's physician giving permission to participate in this exam.**

If YES, MD written clearance required

A.	YES	NO	Angina/chest pain, shortness of breath		Q.	YES	NO	Emotional/mental health disorder (anxiety, depressions, bipolar)	
B.	YES	NO	Heart attack	Date: _____	R.	YES	NO	Liver disease (hepatitis A or B/jaundice/cirrhosis)	
C.	YES	NO	Heart surgery	Date: _____	S.	YES	NO	Hives, itching or skin rash	
D.	YES	NO	Stroke	Date: _____	T.	YES	NO	Sexually transmitted disease(s)	
E.	YES	NO	Congestive heart failure		U.	YES	NO	Stomach or duodenal ulcers	
F.	YES	NO	Coronary artery or other heart disease		W.	YES	NO	Tuberculosis or pertussis	
G.	YES	NO	Arteriosclerosis/coronary occlusion		X.	YES	NO	Congenital heart disease	
H.	YES	NO	Epilepsy/seizures/convulsions		Y.	YES	NO	Pacemaker	
I.	YES	NO	Valve damage following heart transplant		Z.	YES	NO	Cancer/chemo/radiation therapy	
J.	YES	NO	Infective endocarditis (heart infection)		AA.	YES	NO	Implanted cardio-defibrillator	
K.	YES	NO	Kidney/renal disease		BB.	YES	NO	Immune suppression or deficiency	
L.	YES	NO	HIV positive/AIDS		CC.	YES	NO	Artificial/prosthetic joint replacement (knee or hip)	
M.	YES	NO	Hepatitis C		DD.	YES	NO	Artificial/prosthetic heart valves	Date: _____
N.	YES	NO	Abnormal bleeding, bruise or history of transfusion. Taking aspirin or blood thinner?		EE.	YES	NO	Alcohol Abuse (alcohol rehabilitation)	Date: _____
O.	YES	NO	Lung/respiratory condition (asthma, bronchitis, emphysema)		FF.	YES	NO	Drug abuse (cocaine, methamphetamines, heroin, crack) or drug rehabilitation	
P.	YES	NO	Diabetes		GG.	YES	NO	High blood pressure	

Turn Page Over ➡

Candidate # _____	**Cubicle #** _____

Letter	Explanation for "YES" answers in **question 8**

9. **YES** **NO** 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. **YES** **NO** Do you have any other diseases, conditions, or problems that have not been listed? If yes, please explain:

Other Conditions	Explanation

11. **YES** **NO** 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)?

If so, please list the appropriate medication(s) below:

12. Please list any **premedication, medications, pills, or drugs with dosage** which you are taking both prescription and non prescription. **(Must be completed the DAY OF THE EXAMINATION)**

	Medication	**Reason Prescribed**
1.		
2.		
3.		
4.		
5.		

13. **WOMEN ONLY**

YES **NO** Are you pregnant or is there any possibility that you might be pregnant?

If yes, when is your expected due date? _____

YES **NO** Are you currently breastfeeding?

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

CLASS

DENTAL CANDIDATES: Any item on the Medical History with a "YES" response, in questions #8A THROUGH #8M require medical clearance from a licensed physician. 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 examination.

I certify that I have read and understood the 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 Initials Only ***Date***

SRTA | Post-Operative Care Agreement

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

Candidate Sequential: _____

PLACE ID LABEL HERE

Test Site: _____

Candidate Information

Candidate Seq. Number: _____

Examination Site: _____

Examination Date: _____

Procedure

☐ Restorative

☐ Periodontal

Patient Information

Name (Print): _____ Address: _____

Today's Date: City, State, Zip Code: _____

The SRTA Examination is the process for determining if a Dentist/Dental Hygienist has the minimal practical skills necessary to obtain a license to practice Dentistry/Dental Hygiene; 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/Dental Hygienist. You may visit a Dentist/Dental Hygienist 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/Dental Hygiene.

_____ _____

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 SRTA dental/dental hygiene 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/Dental Hygienist if post-operative care is necessary.

_____ _____

Name 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 SRTA and associated testing agencies, and the School of Dentistry/Dental Hygiene 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

SRTA | Incident Disclaimer

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

Candidate Sequential: _____

PLACE ID LABEL HERE

Test Site: _____

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 Sequential Number*	***Patient:*** *Printed Name*
Candidate: *Signature*	***Patient:*** *Signature*
Candidate: *Date Signed*	***Patient:*** *Date Signed*

SRTA | Patient Consent, Disclosure, & Assumption of Responsibility

I authorize the individual listed below (the "Candidate") to perform the following dental procedure(s) during the administration by the testing agency (SRTA) of a dental licensing examination (the "Examination"):

- ☐ **Posterior Amalgam Prep & Restoration**
- ☐ **Posterior Composite Prep & Restoration**
- ☐ **Anterior Composite Prep & Restoration**
- ☐ **Periodontal Treatment**

Candidate Sequential: _____

PLACE ID LABEL HERE

Test Date: _____

Test Site: _____

Acknowledgement

I understand the following:

- the Candidate may not be a licensed dentist. **(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.

Disclosure of Risks

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

Adequacy of Treatment

I understand that the treatment 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.

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, 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.

Medical Condition and Medications

I have fully disclosed my current medical conditions and medical history to the best of my knowledge. I understand that if I am taking medications that are associated with certain chronic conditions, I may not be accepted as a patient for the Examination. I have fully disclosed all medications that I am currently taking. I have been informed that patients who are taking bisphosphonate medications may be as 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 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.

Agreement

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, and any acts of the Candidate (including negligence), 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 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 procedure(s) – candidates should initial, but NOT sign in order to preserve anonymity.

SRTA | Periodontal Treatment Selection Worksheet

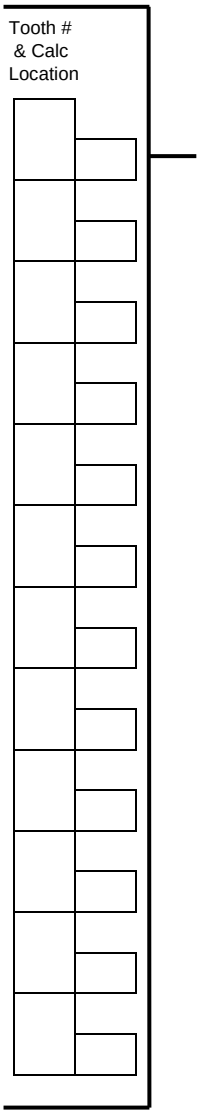
By the day of the examination all information on this form must be accurately transferred electronically to the computer-based Periodontal Evaluation Form.

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.

Candidate Sequential: _____

PLACE ID LABEL HERE

Test Site: _____



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=Distal, 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

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.**