

## New Jersey School Of Dental Assisting Inc.

61 Livingston Ave  
 New Brunswick, NJ 08901  
 800-726-2137  
[njdentalassist@att.net](mailto:njdentalassist@att.net)  
**DO NOT MAIL**

**Mailing Address**  
 Administrative Office  
 15 Wellington Ln.  
 Lakewood, NJ 08701

939 Lacey Rd  
 Forked River, NJ 08731  
 800-726-2137  
[njdentalassist@att.net](mailto:njdentalassist@att.net)  
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*State Radiology Course is approved and accredited by the NJ Radiologic Technology Board of Examiners*

### APPLICATION X-RAY PROGRAM

Student's Name: \_\_\_\_\_ Email: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Social Security Number: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ Have you ever been convicted of a criminal offense?  Yes  No  
 Are you of good moral character?  Yes  No Do you have dental assistant experience or training?  Yes  No  
 In case of emergency, whom should we contact? Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Location: NB FR X-Ray Class Start Date \_\_\_\_\_

**EDUCATIONAL DATA**

All applicants must be 18 years old. of good moral character and have a high school diploma or GED. Diplomas not issued in the USA must be translated and evaluated and be equal to a high school education received in the USA

Please submit copy of USA diploma or GED or foreign translated and evaluated diploma \_\_\_\_\_

SCHOOL	NAME AND LOCATION	GRADUATED (Y/N)	MAJOR	GPA
High School				
College				
Other (Specify)				

Subjects of Special Study: \_\_\_\_\_

Special Training and Skills: \_\_\_\_\_

**DENTAL EXPERIENCE (Work or Dental Training Required)** (You may use the space provided below, or attach a separate piece of paper.)

References: Give the names of three persons not related to you, whom you have known at least one year.

**REFERENCES**

NAME	ADDRESS	PHONE	BUSINESS
1.			
2.			
3.			

I certify that all the information provided is complete and accurate to the best of my knowledge.

Applicant's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Please mail all applications to the Administrative Office

NJ School of Dental Assisting  
61 Livingston Ave.  
New Brunswick, NJ 08901  
**DO NOT MAIL TO ADDRESS**

Mailing Address  
15 Wellington Ln  
Lakewood, NJ 08701  
Tel: 800-726-2137  
Fax: 888-780-6972

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Forked River, NJ 08731  
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**ENROLLMENT AGREEMENT**

Name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_  
Address: \_\_\_\_\_  
Telephone Number: \_\_\_\_\_ Cell Number: \_\_\_\_\_ Email: \_\_\_\_\_  
Program: State Radiology Course Hours: 70 Tuition: \$620

Class Schedule: Sundays from 9 a.m. to 1:20 p.m. Start Date: \_\_\_\_\_ End Date: \_\_\_\_\_

Location: NB FR

The tuition will cover the entire program. The student is responsible for the total tuition plus all fees payable with application.. All tuition monies paid by the student will be refunded if the applicant cancels this contract within three business days from signing. This refund, less all fees is applicable even if instruction has begun.

<b>Fees:</b>	Admin Fees	\$25.00
	Text Book	\$75.00
	Supply Fee	\$75.00
	Other (Insurance)	\$20.00
	Tuition	<u>\$620.00</u>
	<b>Total</b>	<b>\$815.00</b>

**This is to be paid in full with application. (No application will be accepted without payment in full)**

**Tuition Refund Policy**

New Jersey School of Dental Assisting will refund a portion of the tuition calculated on a per session pro rata basis in the event of notification by the student of withdrawal from the school or termination by the school prior to completion of the course or program. The application fee, registration fee, textbooks, student workbooks including insurance costs are non refundable. The director of the school must be notified in writing within five business days of the date of withdrawal.

The student agrees to maintain regular attendance and to abide by the rules and regulations of the school. The student understands that regular attendance is the obligation of the student and that the school's policy regarding absence and make-up as stated in the school catalog will apply. Violation of school rules and regulations may subject the student to dismissal.

The student acknowledges receiving a copy of this agreement, the school catalog and written confirmation of acceptance prior to signing this contract. The student by signing this contract acknowledges that he/she has read this contract and understands the terms and conditions and agrees to the conditions outlined in this contract. Signing of this contract by the school is written confirmation by the school that the above-named student has been approved to enter the above-named program. This agreement is not binding until three business days after signing by both parties. The student and the school will retain a copy of this agreement.

_____ School Directors Signature	_____ Date	_____ Applicants Signature	_____ Date
		_____ Parent/Guardian Signature (if necessary)	_____ Date