

New Jersey School Of Dental Assisting Inc.

61 Livingston Ave
New Brunswick, NJ 08901
800-726-2137
njdentalassist@att.net
DO NOT MAIL TO THIS ADDRESS

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

939 Lacey Rd
Forked River, NJ 08731
800-726-2137
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
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: _____

EXPERIENCE

Please describe any dental office experience you have had. (You may use the space provided below, or attach a separate piece of paper.)

Character 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

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Mailing Address
15 Wellington Ln
Lakewood, NJ 08701
Tel: 800-727-2137
Fax: 888-780-6972

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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.

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

This is to be paid in full with application..

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