WEEKEND DENTAL ASSISTANT SCHOOL

STUDENT APPLICATION -- **PLEASE PRINT**

NAME_____________________AGE__________DATE _______________
ADDRESS________________________**CITY**_________**ST**______**ZIP**____
HM TELEPHONE_______________________ CELL____________________
EMAIL ADDRESS: ____
HIGH SCHOOL ATTENDED/GED________________________________

POST GRADUATE EDUCATION________________________________
____

WORK EXPERIENCE ____

DENTAL INTERESTS/EXPERIENCES ____________________________
____

CAREER GOALS____
____

PERSONAL GOALS ____
____

In connection with my application with the school, I understand that a consumer report which may contain public record information is being requested. This report may include the following types of information:
Names and dates of previous employers, credit information, etc. I further understand that such report may contain public record information concerning my credit, bankruptcy proceeding, etc. form federal, state and other agencies which maintain such records.

I AUTHORIZE WITHOUT RESERVATION; ANY PARTY OR AGENCY CONTACED TO FURNISH THE ABOVE-MENTIONED INFORMATION.

______________________________ ______________________________
Print Name Social Security Number

____
Print Address

____
City, State, Zip code

______________________________ ______________________________
Applicant's Signature Date

Make Tuition Check Payable To: WEEKEND DENTAL ASSISTANT SCHOOL
2600 N Richmond St.
Appleton, WI 54911