NJ NEW JERSEY
HP HEALTH PROFESSIONALS
DI DEVELOPMENT INSTITUTE

Dental Radiology Course Application

Session applying for: Daytime Program [ ] or Evening Program [ ] Start Date _____

Name:_____

Address:_____City_____State_____Zip_____

Telephone: Home _____ Cell _____

Emergency Contact Name: _____ Phone _____

E-Mail:_____ **SS#** _____/ _____ / _____ **Date of Birth:** _____

How did you hear about us? _____

Admission Requirements (Must be included with application):

[ ] Applicant must be at least 18 years of age
(please provide copy of driver's license, passport, or birth certificate)
[ ] Must have high school diploma or GED and provide a copy
(foreign diplomas must be evaluated for US equivalency: $150 extra charge may apply)
[ ] Must be of good moral character
[ ] Must have a minimum of 6 months, full-time, chair-side assisting experience
(verified by employer)
[ ] Must be vaccinated for COVID-19 (Please provide a copy of your vaccine information)

IMPORTANT: Your application will be considered incomplete if the above documentation is not provided with this application.

Moral Character Statement:

Are you of good moral character? Yes No

Have you ever been convicted of any offense of any federal or state law other than a motor vehicle traffic violation? Yes No

If "yes" give date(s) of conviction and type(s) of offense:_____

_____

If "yes", has the court sentence(s) been completed? Yes No
(please submit documentation)

Dental Experience:

Office:_____

Address:_____City_____State_____Zip_____

Telephone: _____ Fax : _____

Brief description of your dental experience: _____

_____

Period of time employed in the dental office: Year(s)_____ Month(s)_____

Circle one: Full time Part time

Are you currently working in a New Jersey dental office? _____

If YES, is this the facility you will be using to complete your clinical education?_____
Is this facility able to perform paralleling and bisecting angle procedures?_____

If NO, do you have another facility to complete your clinical education? _____

*It is the student's responsibility to locate a New Jersey dental facility for clinical education.

Fee: $1,045.00 (This includes application, tuition, workbook, textbook, and lab fees)

Please circle method of payment: Check Visa/ MasterCard / Discover/AmEx

Credit Card #: _____ Exp. Date: _____

Security Code: _____ Billing Address: _____

Cardholder's Name: _____

Cardholder's Signature: _____

*Please make checks payable to: New Jersey Health Professionals Development Institute

Cancellations and Refunds
Withdrawals after class attendance has begun will result in reimbursement according to a pro-rated portion of the tuition calculated on a weekly basis minus the $50 application-processing fee, $175 textbook & workbook fee and $125 laboratory fee. These fees are non-refundable.

Disclosure Statement
NJHPDI reserves the right to cancel or change any courses, instructors, dates and times. The fee charged is for tuition. All food served is complimentary.