Dental Assisting

Program Packet

For More information please call 524-3000 ext. 3200 or 3437
April 16, 2015

Dental Assisting Packets MAY NOT be submitted BEFORE orientation.
Welcome to the EITC Dental Assisting Program. Becoming a Dental Assistant is about becoming a Professional. Professionalism is: What distinguishes people who “HAVE A JOB from those who PURSUE A CAREER.” The following packet explains the expectations of the Dental Assisting program.

Prior to making application to the dental assisting program, individuals should give careful thought and consideration to the physical and mental demands of the dental assisting program and the pressures involved in undertaking the responsibilities of a being a health care provider student.

Completed packet information will be brought with the applicant to the interview with the dental assisting coordinator/instructor which will take place by May 29th.

Applicants will need to call and schedule an interview after orientation with the coordinator/instructor. Interviews will be done on Tuesdays/Thursdays.

**EITC Dental Assisting Mission Statement**

The Dental Assisting Program of EITC provides a comprehensive dental assisting education, enhanced by the State of Idaho recognized skills for Expanded Function Duties, to a diverse student population. The **intent of the program** is to provide quality, job-relevant career training designed to promote quality of life and dental care for the student, patients & community.

**Program Description**

The program follows Idaho State Board of dentistry guidelines. The program consists of:

1. Classroom training – didactic
2. Clinical skills training – hands on
3. Clinical experience in EITC clinic and in area dental offices

**Course Description**

Course curriculum provides training necessary to become an integral part of the dental profession. With the EITC Dental Assisting Program education and two (2) years of work related experience a student may take the national DANB examination for Dental Assistants.

**Length of the Program**

- Three (3) semesters
- Fall Semester – Classes on Mon, Tues, Wed, Thurs, Fri
- Spring Semester – Classes on Mon, Wed, Fri & Core Classes on Tues ,Thurs
- Summer Semester – Externship (250 hr.) Meet as a class once a week

**Degree** - Technical Certificate
Dental Assisting

Dental Assisting curriculum is based on the following:

- Scientific principles
- Dental terminology
- Patient care
- Clinical procedures
- Safety precautions
- OSHA requirements
- Administrative procedures

Program Costs

In addition to the semester registration fees, a Dental Assisting student can expect to spend an approximate total of $1,650 on books, supplies (scrubs, lab jacket, goggles, and shoes), liability insurance, CPR, first aid, and dental conventions and Dental Assisting National Board (DANB) and/or National Occupational Competency Testing Institute (NOCTI) program exit assessments.

Dental Examination

Each student is required to have a dental exam before being admitted to the EITC Dental Assisting Program. The exam may be done by a dentist of your choice and the form in this packet must be completed by the dentist and turned in with the completed packet.

Insurance - Each student will need proof of insurance

- Health Insurance – EITC student fees / Parent / Spouse
- Malpractice Insurance – paid for with registration fees – insurance covers student for program clinical classes & externship hours only
- Without proof of insurance and/or if coverage lapses during any given semester the student will not be allowed to perform any clinical procedure and/or externship.

A student will be responsible for their own insurance and all medical costs during the course of the program.

Personal Appearance

- Piercing – No facial piercing will be allowed
- Ears – One piercing per ear… only small post type earrings may be worn
- Oral piercing – Tongue, lip or cheek piercing is STRICTLY PROHIBITED during the time spent in the dental assisting program if a student comes to class with oral and/or facial piercings they will be asked to leave.
- Tattoos – Any visible tattoo will need to be covered at all times (students with visible tattoos may experience difficulty in finding employment in area dental offices.)
- BBBB rule: No exposed backs, buttocks, breasts, or bellybuttons
• Finger Nails – Artificial nails are not accepted in a clinical/lab setting
• It is recommended that the use of Tobacco Products be discontinued

**Attendance Policy**

EITC Health Professions Division requires regular attendance of classes as part of graduation requirements. Ninety percent attendance is required for classroom, lab, and clinicals. Grades will drop one letter grade for any absences over 90%. Tardiness will not be tolerated.

**Confidentiality**

EITC Dental Assisting students will be required to sign a Clinical Confidentiality Contract – each student will assume the responsibility for confidentiality. All patient information is considered confidential & will not be discussed with anyone and will not be copied. Breach of contract will result in the offender being suspended from the program.

**Clinical Patients**

Students will need to provide patients for the following classes: (Patients will need permission from their dentist)

- **Fall Semester:** 1 patient for Home Health Care Instructions
  3 patients for Radiology (2 adults -18 or older, 1 child - 5-10yrs)

- **Spring Semester:** 3 patients for State Board Testing (Adult 1 or 2 – 16yrs or older & Child 1 or 2 – 5-11yrs)
  Each patient will need to be examined and have a scaling by a dentist at their own expense.

- Dental assistants are exposed to unpleasant sights, sounds and smells. They are exposed to blood, saliva, dental materials and products and communicable diseases.
- Dental assisting requires mature individuals who are emotionally stable that are able to be discreet and have patience and good communication and soft skills.
- Dental assistants also need to have positive self-esteem, have a tolerance toward others and be able to communicate appropriately both verbally and with body language.
- Dental assistants also need to have good manual dexterity, the ability to multi-task, have good organizational skills, and the ability to use critical thinking to solve problems.

I have read the above Dental Assisting Orientation Outline and understand what is expected of me as a Dental Assisting Student.

______________________________

Student signature

______________________________

Date
Application for Admission

Name __________________________________________________________________________________________

                      First                      Middle                      Last                      Former Name (if applicable)

Home Address ______________________________________________________________________________________

                      Street                      City                      State                      Zip Code

Permanent Address (if different from above) ____________________________________________________________

EITC Student ID ____________________ Home Phone ____________________

Business Phone ____________________ Male _____ Female _____

EDUCATION

Official transcript(s) must be received by the office of admissions and records.

<table>
<thead>
<tr>
<th>Name of School</th>
<th>Location of School</th>
<th>From Month/Year</th>
<th>To Month/Year</th>
<th>Diploma or degree rec’d?</th>
<th>Major/Minor</th>
</tr>
</thead>
<tbody>
<tr>
<td>High School</td>
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<tr>
<td>College</td>
<td></td>
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</tbody>
</table>

Professional Licenses or Certification

<table>
<thead>
<tr>
<th>Type</th>
<th>Issued by Which State or Agency</th>
<th>License Number</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

Follow Up Information

It is important that we follow up our students after graduation to be sure they obtain appropriate employment. Please provide information about two people who will always know where to locate you.

<table>
<thead>
<tr>
<th>Name</th>
<th>Mailing Address</th>
<th>Telephone</th>
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</thead>
<tbody>
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</tbody>
</table>
Health Related Work/Volunteer Experience

Employer ______________________________________  Phone ___________________  Ext ______________
Address ______________________________________________________________________________________

Supervisor’s Name _________________________________________  Title ____________________________

Dates Employed: From ________ To ________  Job Duties ______________________________________
Reason for Leaving __________________________________________

Employer ______________________________________  Phone ___________________  Ext ______________
Address ______________________________________________________________________________________

Supervisor’s Name _________________________________________  Title ____________________________

Dates Employed: From ________ To ________  Job Duties ______________________________________
Reason for Leaving __________________________________________

Please Read and Sign the Following

I hereby certify that the information contained in this application is true and complete to the best of my knowledge. I understand that any misinterpretation or falsification of information is cause for denial of admission or expulsion from the college. I understand that illegal use, possession, and/or misuse of drugs are reasons for immediate dismissal from the nursing program. I understand that a felony conviction may prevent me from obtaining a nursing license.

_____________________________________________________________        ______________________________
Signature of Applicant                                      Date

In Case of Emergency, Notify:

Name _________________________________________________________ Phone _______________________
Street Address _____________________________________________ City ___________________ State/Zip___________
Health Professions Program Packet checklist for applicants

Late & Incomplete packets will NOT be accepted for review.

Students must provide documentation of completed immunizations as specified below:

<table>
<thead>
<tr>
<th>Immunization or Titer</th>
<th>Date Given</th>
<th>Take during - to be current through the end of the program</th>
<th>Eligible:</th>
<th>Packet Review Date &amp; Comments:</th>
</tr>
</thead>
<tbody>
<tr>
<td>MMR #1</td>
<td></td>
<td>Complete by May 1&lt;sup&gt;st&lt;/sup&gt;</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>MMR #2</td>
<td></td>
<td>Complete by May 1&lt;sup&gt;st&lt;/sup&gt;</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Hep A #1</td>
<td></td>
<td>Complete by May 1&lt;sup&gt;st&lt;/sup&gt;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hep A #2</td>
<td></td>
<td>Complete by May 1&lt;sup&gt;st&lt;/sup&gt;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hep B #1</td>
<td></td>
<td>Complete by May 1&lt;sup&gt;st&lt;/sup&gt;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hep B #2</td>
<td></td>
<td>Complete by May 1&lt;sup&gt;st&lt;/sup&gt;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hep B #3</td>
<td></td>
<td>Complete by May 1&lt;sup&gt;st&lt;/sup&gt;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Varicella #1</td>
<td></td>
<td>Complete by May 1&lt;sup&gt;st&lt;/sup&gt;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Varicella #2</td>
<td></td>
<td>Complete by May 1&lt;sup&gt;st&lt;/sup&gt;</td>
<td></td>
<td></td>
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<tr>
<td>DPT #1</td>
<td></td>
<td>Complete by May 1&lt;sup&gt;st&lt;/sup&gt;</td>
<td></td>
<td></td>
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<tr>
<td>DPT #2</td>
<td></td>
<td>Complete by May 1&lt;sup&gt;st&lt;/sup&gt;</td>
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<tr>
<td>DPT #3</td>
<td></td>
<td>Complete by May 1&lt;sup&gt;st&lt;/sup&gt;</td>
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<td></td>
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<tr>
<td>DPT #4</td>
<td></td>
<td>Complete by May 1&lt;sup&gt;st&lt;/sup&gt;</td>
<td></td>
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<tr>
<td>DPT #5</td>
<td></td>
<td>Complete by May 1&lt;sup&gt;st&lt;/sup&gt;</td>
<td></td>
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<tr>
<td>Polio #1</td>
<td></td>
<td>Complete by May 1&lt;sup&gt;st&lt;/sup&gt;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Polio #2</td>
<td></td>
<td>Complete by May 1&lt;sup&gt;st&lt;/sup&gt;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Polio #3</td>
<td></td>
<td>Complete by May 1&lt;sup&gt;st&lt;/sup&gt;</td>
<td></td>
<td></td>
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<tr>
<td>Polio #4</td>
<td></td>
<td>Complete by May 1&lt;sup&gt;st&lt;/sup&gt;</td>
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<tr>
<td>** Menactra - Meningococcal**</td>
<td></td>
<td>Complete by May 1&lt;sup&gt;st&lt;/sup&gt;</td>
<td></td>
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<tr>
<td>TB expires</td>
<td></td>
<td>Due in August prior to start of class</td>
<td></td>
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</tr>
<tr>
<td>Drug and alcohol screen</td>
<td></td>
<td>To be included in the packet. A random test will be done during the semester.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Letter of Intent</td>
<td></td>
<td>Complete by May 1&lt;sup&gt;st&lt;/sup&gt;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dental exam</td>
<td></td>
<td>To be included in the packet</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Typing Test</td>
<td>= 35 or &gt;</td>
<td>90% Acc. Or &gt;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Photo of self</td>
<td></td>
<td>To be included in the packet</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Background Check</td>
<td></td>
<td>To be completed in May prior to turning in packet.</td>
<td></td>
<td></td>
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**Requirements**

<table>
<thead>
<tr>
<th>Requirements</th>
<th>Semester</th>
<th>Grade</th>
<th>Equivalency:</th>
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</thead>
<tbody>
<tr>
<td>DTL 121</td>
<td>Fall</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DTL 124</td>
<td>Fall</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DTL 125</td>
<td>Fall</td>
<td></td>
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<tr>
<td>DTL 126</td>
<td>Fall</td>
<td></td>
<td></td>
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<tr>
<td>DTL 129</td>
<td>Fall</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HCT 100</td>
<td>Fall</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CIS 101</td>
<td>Spring</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DTL 127</td>
<td>Spring</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DTL 128</td>
<td>Spring</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DTL 131</td>
<td>Spring</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ENG 101</td>
<td>Spring</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PSY 101</td>
<td>Spring</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DTL 132</td>
<td>Summer</td>
<td></td>
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</tr>
</tbody>
</table>

If you have any transfer credits, you must provide in your packet, a transfer equivalency print out from the EITC registrar to show we have your information entered along with your Program Evaluation from WebAdvisor.
All core courses must be passed with a minimum of a C- (70%), and must be passed consecutively before continuing on to the next course.

* All DTL program courses must be passed with a minimum of a C (75%), and must be passed consecutively before continuing on to the next course.

**Interview Question Form – By May 1st**

Name______________________________________________________ Date ______________________________

Please answer the following questions:

1. What are the top three reasons you want to be a dental assistant? _____________________________________
   __________________________________________________________________________________________
   __________________________________________________________________________________________
   __________________________________________________________________________________________

2. Do you see yourself actually working in the field when the course is completed? __________________________
   Explain ______________________________________________________________________________________________________
   __________________________________________________________________________________________
   __________________________________________________________________________________________

3. What do you think a dental assistant does? ________________________________________________________
   __________________________________________________________________________________________
   __________________________________________________________________________________________
   __________________________________________________________________________________________

4. Are you able to multi-task? _______________________________  Explain ______________________________
   __________________________________________________________________________________________
   __________________________________________________________________________________________
   __________________________________________________________________________________________

5. What do you think is going to be the most challenging aspect of being a dental assistant? ______________
   __________________________________________________________________________________________
   __________________________________________________________________________________________
   __________________________________________________________________________________________

6. What are your greatest strengths? ________________________________________________________________
   __________________________________________________________________________________________
   __________________________________________________________________________________________
   __________________________________________________________________________________________

7. What are your greatest weaknesses? __________________________________________________________________
   __________________________________________________________________________________________
Eastern Idaho Technical College
Health Professions Division
Dental Assisting Program Dental Examination Form – By May 1st

Student’s Name: ____________________________________________ Phone #: _____________________
Alternate Phone: ___________________________ Email: _______________________________________
Address: ______________________________ City: ______________________ State: ______ Zip: ________
Dentist’s Name: __________________________________ Office Phone#: __________________________
Address: ______________________________ City: ______________________ State: ______ Zip: ________

Is any dental treatment needed at this time?  Yes: ____  No: ____
Explain briefly what type:
___________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________

The above student is scheduled to enter the EITC Dental Assisting Program on: ___________________________

Can the needed procedures be completed before the above enrollment date:  Yes: ____  No: ____

Please describe the general condition of the student’s oral cavity: ________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________

In your opinion, what is the attitude of this person regarding the health and care of the oral cavity? __________
___________________________________________________________________________________________

The above student can have x-rays taken at EITC Dental Assisting Clinic as part of the Dental Assisting Program?
Yes: _____ No: _____

The above student can have their teeth bleached /whitened at EITC Dental Assisting Clinic as part of the Dental Assisting Program? Yes: _____ No: _____

Dentist Signature: ____________________________________________ Date: __________________________
Eastern Idaho Technical College
Dental Assisting Program
Dental Office Observation Form – By May 1st

Please print the following information:

Name ____________________________________________ Date Observed ______________________

Dental Office __________________________ Address ___________________________ Phone ___________

Dentist _______________________________________

Dental Assistant (s) ___________________________________________________________________________

Hygienist (s) _______________________________________________________________________________

Front Office Staff _____________________________________________________________________________

Hours Observed _____________________________

Who did you observe _________________________________________________________________________

What tasks did you observe? __________________________________________________________________

___________________________________________________________________________________________

___________________________________________________________________________________________

___________________________________________________________________________________________

Dental Office Staff Signature ______________________________________ Date ______________________

What if anything, stood out to you most? _________________________________________________________

___________________________________________________________________________________________

___________________________________________________________________________________________

___________________________________________________________________________________________
BACKGROUND CHECK

Criminal background checks are a requirement of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). Criminal background checks are necessary to meet clinical practicum site requirements during Eastern Idaho Technological Colleges’ (EITC) Health Professions programs.

Individuals who have been charged and/or convicted of a felony or misdemeanor for battery, assault, substance abuse and theft will not be accepted in EITC’s Health Professions programs.

Backgroundchecks.com is the only approved company that meets HCA requirements.

To register for the background check, print off the instructions from the EITC website along with this packet. These instructions are available on the EITC website – click Programs of Study, then Health Professions – look on the right side of screen for HCA Background Check Instructions.

** You will need to print out your official completed results and provide a copy with your completed application packet.

IMMUNIZATION RECORDS

Read and print the following enrollment form. You will need to provide the records that you currently have to Eastern Idaho Public Health Department. If you are not obtaining immunizations at EIPHD, you will be charged a $10.00 fee to complete your IRIS. Your records will be uploaded to the database. Once the records are complete you may request a print out of your records.

** A copy of your IRIS record must be included in your packet.

You may mail your records along with the enrollment form and a check for $10.00 to:

EIPHD
Attn: Immunizations Program
1250 Hollipark Drive
Idaho Falls, Idaho 83401
533-3235

You may also go directly to the facility. If you chose to go to the facility in person please identify yourself as an EITC student.

Do not wait until the last minute to do this. The Eastern Idaho Public Health Department is not obligated to provide you with this information at your convenience.

Note: Titers are now able to be filed on the IRIS form. You need to have them drawn at Express lab and submit a copy of the results demonstrating immunity. Tell them it is for EITC program entrance.
Express Lab  
Washington Pkwy  
Idaho Falls, ID 83404  
(208) 529-8330

Signing the statement below will allow the health care provider who immunizes me or my child, or appropriate personnel at my child’s school or child care, to submit information regarding immunizations and me or my child to the voluntary Idaho Immunization Reminder Information System (IRIS). This information will be limited to identifying information (such as name and date of birth), immunization information (such as dates and types of immunizations), and location information (such as my correct address). To make sure that correct immunizations are provided, or to verify that I or my child have received immunizations, the information entered into IRIS relating to me or my child may be made available and redisclosed to health care providers, child care providers, or schools.

My consent permits my child’s or my own enrollment in the statewide immunization registry and disclosure of the information relating to me or my child to my or my child’s health care providers, my child’s child care provider, or my child’s school without further consent. I may be asked for information that will help ensure records are accurate and will not be confused with another person’s.

My consent also will allow for the transfer and entry of my or my child’s previous immunization records into the statewide electronic registry.

I give permission to enroll me or my child and to transfer my or my child’s immunization records into the Idaho Immunization Reminder Information System (IRIS) to ensure that this vaccination record is available to my, my or my child’s health care providers, child care providers, and schools. I understand I may be asked for information that will help ensure my or my child’s records are accurate and will not be confused with another person’s records, such as: mother’s maiden name, gender, and child’s eligibility for free vaccine. I authorize inclusion of all information into IRIS and redisclosure of this information from IRIS to authorized users.

<table>
<thead>
<tr>
<th>Child’s Name or My Name</th>
<th>Gender F / M</th>
<th>Race</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Birth</td>
<td>Telephone Number</td>
<td></td>
</tr>
<tr>
<td>Address</td>
<td>Mothers Maiden Name/Guardian First Name</td>
<td></td>
</tr>
<tr>
<td>City State Zip</td>
<td></td>
<td></td>
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<tr>
<td>Signature Relationship to Child Date (if applicable)</td>
<td>Date</td>
<td></td>
</tr>
</tbody>
</table>

IRIS
### Timetable Planner

<table>
<thead>
<tr>
<th>Time</th>
<th>Monday (Course &amp; section)</th>
<th>Tuesday (Course &amp; section)</th>
<th>Wednesday (Course &amp; section)</th>
<th>Thursday (Course &amp; section)</th>
<th>Friday (Course &amp; section)</th>
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</thead>
<tbody>
<tr>
<td>7-8am</td>
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</tr>
<tr>
<td>8-9am</td>
<td>DTL 121</td>
<td>HCT 100</td>
<td>DTL 121</td>
<td>HCT 100</td>
<td>DTL 125</td>
</tr>
<tr>
<td>9-10am</td>
<td>DTL 125</td>
<td>DTL 126</td>
<td>DTL 125</td>
<td>DTL 126</td>
<td>DTL 125</td>
</tr>
<tr>
<td>10-11am</td>
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<td>11-12pm</td>
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<td>12-1pm</td>
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<td>4-5pm</td>
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<tr>
<td>Evenings</td>
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### Sample Registration Form

**Fall Semester**

<table>
<thead>
<tr>
<th>Course #</th>
<th>Section #</th>
<th>Course Title</th>
<th>Credits</th>
<th>Instructor</th>
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</thead>
<tbody>
<tr>
<td>DTL 121</td>
<td>01</td>
<td>Orientation to Dental Assisting/Office Management</td>
<td>2</td>
<td>Roberts</td>
</tr>
<tr>
<td>DTL 124</td>
<td>01</td>
<td>Basic Dental Science/Medical Situations</td>
<td>3</td>
<td>Roberts</td>
</tr>
<tr>
<td>DTL 125</td>
<td>01</td>
<td>Dental Operatory Procedures</td>
<td>4</td>
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**Total Credits** 16