DENTAL EXAMINATION
ASSISTANT CERTIFICATION

Candidate Sequential:_____

PLACE ID LABEL HERE

Test Site: _____

Place Assistant Photograph here

Candidate Agreement for the Utilization of a Chairside Assistant during the ADEX Restorative/Periodontal Clinical Examination in Dentistry.

ATTENTION: If you are using a chairside dental assistant during the ADEX Patient Treatment Clinical Examinations you must complete this agreement. Attach a photograph of your assistant in the two designated areas on this form. This form must be presented to the Chief Examiner the day of the examination, otherwise, you will not be permitted to utilize a chairside assistant.

I, Candidate ID: | | | | | | And Candidate Sequential: | | | | At Test Site: | |

Affirm that: Assistant Name: _____ Assistant Address: _____

Assistant Telephone #: _____ Will act as a chairside assistant for the examination date listed below.

I further affirm that the assistant is adequately knowledgeable about infection control and dental procedures so as not to cause harm to the patient or other personnel with whom the assistant may come in contact with.

I affirm that said chairside assistant is not a dentist or dental hygienist (licensed or unlicensed), fourth year dental student, final year hygiene student, dental technician or any dental assistant employing expanded duty functions.

I affirm that the chairside assistant will wear proper attire and the photo identification badge at all times while assisting me.

I understand that I am responsible for any and all actions and behavior of the chairside assistant, that may violate the examination policy of the ADEX Examination.

As the chairside assistant I affirm that I will maintain the anonymity of all candidates and examiners that I may encounter .

I understand that as a chairside assistant, I am not to enter the scoring area at any time prior to, during and following the published times of the examination.

I understand that failure to comply with any of the aforementioned articles will result in the candidates' dismissal from and failure of the examination. Additional penalties may also include restrictions on the candidates' ability to sit for future examinations.

By signing below, I acknowledge that all infractions will be reported to the State Boards of Dentistry.

This agreement (with the attached photo of the assistant) will be held by the Chief Examiner on-site and will be sent to the Central Office when the Examination is complete.

Signature of Candidate:_____ Date: _____

Signature of Assistant _____ Date: _____

Authorized Chairside Assistant

Place Assistant Photograph here

CDCA

Candidate Sequential Number

_____

Chairside Assistant Name

_____

Date

_____

Site