Patient Consent, Disclosure, and Assumption of Responsibility

Candidate Sequential:____
Candidate ID:
PLACE ID LABEL HERE
Test Site:____

Cubicle #

I authorize the individual listed below (the "candidate") to perform the following dental procedure(s) during the administration by the testing agency CDCA of a dental licensing examination (the "examination"):

- ☐ **Posterior Amalgam Prep and Restoration**
- ☐ **Posterior Composite Prep and Restoration**
- ☐ **Anterior Composite Prep and Restoration**
- ☐ **Periodontal Scaling**

Acknowledgment

I understand the following:

- the candidate is not a licensed dentist and the State Board has not yet determined whether the candidate has the requisite skills to attain a license
- the testing agency has no knowledge of the candidate's skill or competence and makes no promises about them
- any arrangements between the candidate and me regarding my serving as a patient (including any financial arrangements) are solely between the candidate and me, and such arrangements do not involve the testing agency in any way
- the testing agency has no duty to, and will not, notify me of inadequate work done by the candidate during the examination
- it is my responsibility to have any and all dental work performed by the candidate checked by a licensed dentist to determine that it is satisfactory

Disclosure of Risks

The candidate has explained to me the risks involved in the procedures the candidate will perform on me. The nature and purpose of the dental procedure(s), as well as the risks and possible complications, have been explained to me to my satisfaction by the candidate. My questions with regard to the dental procedure(s) have been answered.

Adequacy of Treatment

I understand that the treatment provided during the examination does not necessarily fulfill all my oral health needs, may not be performed correctly, or may not represent my entire treatment plan, and that further treatment may be necessary. I have been informed of the availability of services to complete treatment.

Authorization of Disclosure of Medical Information

I recognize that medical information which could be pertinent to the oral health care I receive in the course of the examination may be communicated to the testing agency, their examiners, the staff and clinicians of the dental school which is the location of the examination, and other medical professionals when deemed medically necessary, or when necessary for the administration for the examination. I authorize this disclosure. This authorization specifically includes the disclosure of radiographs (X-rays), and information about my current medical and dental condition and my prior medical and dental history.

Medical Condition and Medications

I have fully disclosed my current medical conditions and medical history to the best of my knowledge to the candidate. I understand that if I am taking medications that are associated with certain chronic conditions, I may not be accepted as a patient for the examination. I have fully disclosed all medications that I am currently taking to the candidate. I have been informed that patients who are taking bisphosphonate medications may be at risk of osteonecrosis of the jaw after dental treatment or as a result of dental infections. I understand that neither the testing agency nor the school assumes any responsibility or liability regarding the health status of patients or candidates or concerning the procedures conducted by the candidate. As neither the candidate nor patient are considered an employee of the testing agency or school, OSHA regulations do not apply. If an exposure to blood borne agents such as HIV or hepatitis or other infectious conditions occurs, it is not the responsibility of the school or testing agency to provide serologic testing, counseling, follow up care or any other health service.

Candidate Sequential:____
Candidate ID:____
PLACE ID LABEL HERE
Test Site:____

Consent to X-Rays and Photographs

I consent to the taking of appropriate radiographs (X-rays) and the examination of my teeth and gums. I also consent to having testing agency examiners or the staff and clinicians of the dental school take photographs of my teeth and gums for use in future examinations, provided that my name is not in any way associated with the photographs or X-rays.

Anesthesia

I understand that as part of the dental procedure(s), it may be necessary to administer local anesthetics and I consent to the use of such anesthetics by the candidate.

Agreement

I release the CDCA, participating dental schools, and their employees and/or agents from any and all responsibility or liability of any nature whatsoever for their acts, and any acts of the candidate (including negligence), which occur during the course of this examination, and any damages or injuries I may suffer as a result of my participation in the examination. With full knowledge of all the risks described above, I hereby expressly assume all risks as described or which can be inferred from the statements in this document. I further agree that neither the CDCA nor the participating dental schools nor their employees or agents are responsible to provide any medical evaluation, treatment, counseling, follow-up care, or any compensation for any condition or occurrence arising out of any act or omission of the candidate, and I hereby indemnify and agree to hold them harmless from any such claims and expenses, including attorney's fees.

I verify that I am not a dentist (licensed or unlicensed), a dental student in the 4th or final year of dental school, or a dental hygiene student in the final year of school.

By my signature below, I verify that I have read and fully understood the above information, and I agree to the terms of this agreement.

Candidate: Printed Name / Candidate ID #

Candidate Signature

Date

Patient: Printed Name / Date of Birth

Patient Signature / Date

Patient Street Address

Patient City / State / Zip Code

Patient Phone Number / E-mail Address