



Denver Health Dental Assisting Program
938 Bannock St, Denver, Colorado 80204
720-445-6619

Please fill out all of the sections below:

Applicant Information

Applicant Name: _____

Address: _____

City, State and Zip Code: _____

Telephone Number: _____

Email Address: _____

Date of Application: _____

Position(s) applying for: Dental Assisting Student (full time)

How did you hear about this position? _____

Personal Information

Are you a U.S. citizen or approved to work in the United States? Yes No

What document can you provide as proof of citizenship or legal status?

Social Security Number _____ - _____ - _____

Education and Training

High School

Name	Location (City, State)	Year Graduated	Degree Earned

College/University

Name	Location (City, State)	Year Graduated	Degree Earned

Vocational School/Specialized Training

Name	Location (City, State)	Year Graduated	Degree Earned



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Military:

Are you a member of the Armed Services? _____

What branch of the military did you enlist? _____

What was your military rank when discharged? _____

How many years did you serve in the military? _____

What military skills do you possess that would be an asset for this position?

Employer Name: _____

Job Title: _____

Supervisor Name: _____

Employer Address: _____

City, State and Zip Code: _____

Employer Telephone: _____

Dates Employed: _____

Housing and assistance:

Do you need assistance with housing? Y or N If yes, please explain

Do you have dependable transportation? Y or N If yes, please explain.

Do you need assistance with childcare? Y or N If yes, please list how many children.

Classes will run Monday through Friday, from 8:00 AM-5:00 PM.

PLEASE ATTACH COPY OF ESSAY EXPLAINING WHY YOU WOULD LIKE TO BE A DENTAL ASSISTANT.

Applicant Signature: _____ Date: _____

Colorado Healthcare Experiential Learning Pathways to Success "CO HELPS" Subrecipient

Participant Self-Attestation Form

Participant Name _____

Date of Birth _____

Sex Female Male

Hispanic/Latin-X Yes No

Race:

American Indian/Alaskan Native Asian Black/African American

Native Hawaiian/Other Pacific Islander White

Disability Yes No

Veteran Yes No If yes, length of service in days/years? _____

Long-Term Unemployed (27+ Weeks) Yes No

Underemployed Worker Yes No

Highest School Grade Completed (0-12) _____

Highest Education Level Completed:

HS Diploma HS Equivalency IEP Certificate

1+ Years Post-Secondary Post-Secondary Cert/License Associate's Degree

Bachelor's Degree Bachelor's+ Degree

Ex-Offender (Criminal) Yes No

Low Income (Financial Assistance) Yes No

English Language Learner Yes No

Self-Attestation Statement: I certify that the information given on this document is true and accurate to the best of my knowledge and belief. I understand that such information is subject to verification, and I further realize that falsified or fraudulent information may result in the rejection of this document, and subsequent termination from the CO HELPS Apprenticeship Program.

X _____
Participant Signature Date

X _____
(Organization name) Representative Signature Date

EO is the Law

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PColorado Healthcare Experiential Learning Pathways to Success "CO HELPS" Subrecipient

Participant Eligibility Attestation Form

Participant Name _____

Date of Birth _____ SSN* _____

Participant to select item approved elements in which they are self-attesting to:

- 17 years of age or older
- Veteran Status
- Not enrolled in High School

Self-Attestation Statement: I certify that the information given on this document is true and accurate to the best of my knowledge and belief. I understand that such information is subject to verification, and I further realize that falsified or fraudulent information may result in the rejection of this document, and subsequent termination form the CO HELPS Apprenticeship Program.

*SSN is highly encouraged, although optional

X _____
Participant Signature Date

X _____
(Organization name) Representative Signature Date

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