

Registration Form 2024

**Cherry Hill Dental
Program of Dental Assisting
220 Diego Drive
Columbia, MO 65203
Office 573-446-0880
Fax 573-447-3121
annar@chdental.com**

Student Name _____

Address _____

Phone _____ **SS#** _____ **DOB** _____

Educational Background:

(Please list any prior schooling, training, or applicable experiences)

Work History:

(Include Resume if possible)

Dates	Name and Address of Employer	Supervisors Name
-------	------------------------------	------------------

Please describe the detail of the work you performed in this position:

Dates	Name and Address of Employer	Supervisors Name
-------	------------------------------	------------------

Please describe the detail of your role in this position:

Dates Name and Address of Employer Supervisors Name

Please describe the detail of the work you performed in this position:

References:

Please list 2-3 professional references that we may contact

Course Information:

Title: Modern Dental Assisting

Schedule: 8:00 a.m. – 1:00 p.m. Saturdays (10 Consecutive Weeks)

Preferred Start Date:

Tuition and Application:

The current tuition for this course is \$3,400 and the application fee is \$25. Please indicate how you will cover the expense:

___ Paid in full upon starting

___ Other Loan

___ Other (please specify)

___ Care Credit/Credit Solutions

I hereby certify that the facts set forth in the above registration form are true and complete to the best of my knowledge. Cherry Hill Dental hereby is authorized to investigate fully all information provided unless otherwise specified by me.

Signature of Applicant

Date