

TARRANT COUNTY COLLEGE
PIT and FISSURE SEALANT COURSE - DNTA 2000
COURSE REQUIREMENTS AND GENERAL INFORMATION

Course Description

Thank you for registering for the Pit and Fissure Course for dental assistants and dental hygienists. This information packet prepares you to participate in the course. This course is designed to provide in-depth training in Pit and Fissure Sealants to meet the Texas State Board of Dental Examiners (TSBDE) requirements for eight (8) hours of didactic and clinical education and professional development for eight (8) CEUs. The course, taught by qualified faculty with no more than five (5) students per faculty member, ensures individualized hands-on instruction as per CODA requirements.

Required Course Documentation/Forms

The following documents must be completed/signed and brought to class by the course participant. *Course participants or patients will not be treated without these forms.*

- Signed letter from your employer (DDS) on practice letterhead verifying at least two (2) years clinical experience as a dental assistant, per TSBDE requirements, including date of hire. Multiple employer letters may be required to meet the two (2) year minimum requirement
- Copy of current CPR Card per TSBDE rules <https://tsbde.texas.gov/licensing/dental-assistants/dental-assistant-renewal/>
- Copy of completed HIPAA/OSHA Compliance Training
- TCC Dental Hygiene Clinic Notice of Privacy Practices Form
- Patient Registration Form
- Patient Medical History Form
- Procedure Risks and Hazards Form
- Policy/Procedure Acknowledgement Form
- Consent for Treatment Form signed by patient, dentist, and course participant
- Consent for Treatment Plan Form signed by patient, dentist, and course participant indicating teeth numbers and surfaces **

** This allows for hands-on sealant placement with dental assistant/dental hygienist course participants. The **minimum age** recommended age for a sealant patient is 12 years old with fully erupted molars. Please be sure that your selected patient will be cooperative for you to complete the clinical requirement. *Be sure to confirm your patient. No-show patients will result in the course participant not being able to complete the course or receive a refund.*

**** Your patient must have a minimum of four (4) posterior teeth to seal for evaluation in the mouth and must include at least two (2) fully erupted molars.**

** It is strongly recommended that you have more teeth than necessary approved in the event that some teeth are disqualified for current existing or incipient decay, restorations, or sealants at the discretion of the course instructor. **Any DDS approved teeth with decay/ restorations/ sealants will not be accepted.** ****Sharing of patients or using a course participant as a patient is not allowed.**

General Course Requirements

- Must attend the entire eight (8) hours of training per TSBDE requirements.
 - Per OSAP guidelines, must attend the course in professional clinical attire: scrubs and closed-toed shoes w/socks. Please refrain from wearing artificial nails, nail polish, and jewelry
3. Course participants and patient safety is important and failure to comply with course requirements may prevent completion of the course training

General Course Information

- Course participants will be provided a Certificate of Completion and copies of the Lab/Clinic Evaluations at course completion if all course objectives have been met and verified by the attending instructor
- Questions regarding the course can be directed to Health Sciences-health.sciences@tccd.edu or 817-515-6435
- Day of Course/8:00 am-5:00pm- Dental Hygiene Clinic 817-515-6324 in case of an emergency

**** Refund Policy: Course participants may drop the course for a 100% refund prior to the start of the course. No refunds will be given once the course has started and contact Business Services/817-515-4729 for a paid receipt**

COURSE SUPPLIES – Each course participant is required to bring:

- A minimum of four (4) sterilized, caries-free posterior teeth (premolars/molars accepted but must have at least two molars) mounted in lab stone. Oral surgeons are good sources and should be contacted well in advance of the course date. **Course participants will not be allowed to complete the course without the mounted teeth – contact** Health Sciences-health.sciences@tccd.edu or 817-515-6435 **if not able bring mounted practice teeth**
- Protective eyewear and scrub cap
- Pen, paper, highlighter
- Copy of current CPR Card. A hands-on component is required. 100% online renewal will not be accepted.
- Copy of completed HIPAA/OSHA Compliance Training
- Completed TCC Dental Hygiene Clinic Notice of Privacy Practices Form
- Completed Patient Registration Form
- Completed Medical History Form
- Completed Procedure Risks and Hazards Form
- Completed Policy/Procedure Acknowledge Form
- Completed Consent for Treatment Form signed by the patient, dentist, and course participant
- Completed consent for Treatment Plan Form signed by the patient, dentist, and course participant indicating teeth numbers and surfaces**

PROVIDED COURSE SUPPLIES - Included in course fee

- Disposable gown, exam gloves, and Level 3 face mask for course participant
- Protective eyewear for patient
- Sterile pack (mouth mirror, caries-detecting explorer, cotton pliers, scaler, articulating paper holder, AW syringe tips on covered exam tray
- Disposables (dry angles, cotton rolls, cotton-tipped applicators, 2x2 gauze, articulating paper, patient bibs/chain, surface barriers, prophylaxis angle and brush, HVE/saliva ejector, floss, and lab jacket)
- P & F Sealant materials
- Topical fluoride gel
- Curing light
- Low speed handpiece w/prophylaxis angle attachment
- Course handouts and Course Certificate of Completion
- Campus map - Park in white spaces in Lots F or G
- Room assignment: NHSC 1112 (Classroom); NHSC 1101 (Dental Hygiene Clinic)
- Drink and snack vending available

HOTEL INFORMATION

Hampton Inn & Suites Dallas-DFW ARPT W-SH 183 Hurst

1600 Hurst Town Center Dr.
Hurst, TX 76054-6236
817-503-7777

Holiday Inn Express & Suites DFW West – Hurst

820 Thousand Oaks Dr.
Hurst, TX 76054
(817) 427-1818

Hyatt Place Fort Worth - Hurst

1601 Hurst Town Center Drive
Hurst, Texas, USA, 76054
Tel: +1 817 577 3003

Hilton Garden Inn Dallas at Hurst Conference Center

1615 Campus Dr.
Hurst, TX 76054
817-281-5800

TARRANT COUNTY COLLEGE
PIT and FISSURE SEALANT COURSE
COURSE AGENDA

8:00 – 8:30am	Check-In Review Treatment Plans	NHSC 1112 (Classroom)
8:30 – 10:30am	Lecture	NHSC 1112 (Classroom)
10:30am-12:00pm	Lab Evaluation	NHSC 1101 (Dental Hygiene Clinic)
12:00-12:45pm	LUNCH	On your own (feel free to bring something)
12:45-1:00pm	Pre-Clinical Meeting	NHSC 1112 (Classroom)
1:00 – 1:30pm	Clinic/Patient Setup	NHSC 1101 (Dental Hygiene Clinic)
1:30 – 5:00pm	Clinic Evaluation	NHSC 1101 (Dental Hygiene Clinic)

****Note:** Patients should plan to arrive between 12:45-1:00pm and be seated in the hallway chairs outside the Dental Clinic. *Patient parking is available only in the white outlined parking spaces in Parking Lots F & G (see campus map).* Course participants are restricted to one patient only. Please notify your patient not to bring any other family members or children to the appointment. No one under the age of 18 can be unattended without adult supervision

****Snack and beverage vending machines are available****

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

- Are you under a physician's care now? Yes No If yes, please explain: _____
- Have you ever been hospitalized or had a major operation? Yes No If yes, please explain: _____
- Have you ever had a serious head or neck injury? Yes No If yes, please explain: _____
- Are you taking any medications, pills, or drugs? Yes No If yes, please explain: _____
- Do you take, or have you taken, Phen-Fen or Redux? Yes No _____
- Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes No _____
- Are you on a special diet? Yes No
- Do you use tobacco? Yes No
- Do you use controlled substances? Yes No

Women: Are you Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No

Are you allergic to any of the following?
 Aspirin Penicillin Codeine Local Anesthetics Acrylic Metal Latex Sulfa drugs
 Other If yes, please explain: _____

Do you have, or have you had, any of the following?

- | | | | |
|--|--|--|---|
| AIDS/HIV Positive <input type="radio"/> Yes <input type="radio"/> No | Cortisone Medicine <input type="radio"/> Yes <input type="radio"/> No | Hemophilia <input type="radio"/> Yes <input type="radio"/> No | Radiation Treatments <input type="radio"/> Yes <input type="radio"/> No |
| Alzheimer's Disease <input type="radio"/> Yes <input type="radio"/> No | Diabetes <input type="radio"/> Yes <input type="radio"/> No | Hepatitis A <input type="radio"/> Yes <input type="radio"/> No | Recent Weight Loss <input type="radio"/> Yes <input type="radio"/> No |
| Anaphylaxis <input type="radio"/> Yes <input type="radio"/> No | Drug Addiction <input type="radio"/> Yes <input type="radio"/> No | Hepatitis B or C <input type="radio"/> Yes <input type="radio"/> No | Renal Dialysis <input type="radio"/> Yes <input type="radio"/> No |
| Anemia <input type="radio"/> Yes <input type="radio"/> No | Easily Winded <input type="radio"/> Yes <input type="radio"/> No | Herpes <input type="radio"/> Yes <input type="radio"/> No | Rheumatic Fever <input type="radio"/> Yes <input type="radio"/> No |
| Angina <input type="radio"/> Yes <input type="radio"/> No | Emphysema <input type="radio"/> Yes <input type="radio"/> No | High Blood Pressure <input type="radio"/> Yes <input type="radio"/> No | Rheumatism <input type="radio"/> Yes <input type="radio"/> No |
| Arthritis/Gout <input type="radio"/> Yes <input type="radio"/> No | Epilepsy or Seizures <input type="radio"/> Yes <input type="radio"/> No | High Cholesterol <input type="radio"/> Yes <input type="radio"/> No | Scarlet Fever <input type="radio"/> Yes <input type="radio"/> No |
| Artificial Heart Valve <input type="radio"/> Yes <input type="radio"/> No | Excessive Bleeding <input type="radio"/> Yes <input type="radio"/> No | Hives or Rash <input type="radio"/> Yes <input type="radio"/> No | Shingles <input type="radio"/> Yes <input type="radio"/> No |
| Artificial Joint <input type="radio"/> Yes <input type="radio"/> No | Excessive Thirst <input type="radio"/> Yes <input type="radio"/> No | Hypoglycemia <input type="radio"/> Yes <input type="radio"/> No | Sickle Cell Disease <input type="radio"/> Yes <input type="radio"/> No |
| Asthma <input type="radio"/> Yes <input type="radio"/> No | Fainting Spells/Dizziness <input type="radio"/> Yes <input type="radio"/> No | Irregular Heartbeat <input type="radio"/> Yes <input type="radio"/> No | Sinus Trouble <input type="radio"/> Yes <input type="radio"/> No |
| Blood Disease <input type="radio"/> Yes <input type="radio"/> No | Frequent Cough <input type="radio"/> Yes <input type="radio"/> No | Kidney Problems <input type="radio"/> Yes <input type="radio"/> No | Spina Bifida <input type="radio"/> Yes <input type="radio"/> No |
| Blood Transfusion <input type="radio"/> Yes <input type="radio"/> No | Frequent Diarrhea <input type="radio"/> Yes <input type="radio"/> No | Leukemia <input type="radio"/> Yes <input type="radio"/> No | Stomach/Intestinal Disease <input type="radio"/> Yes <input type="radio"/> No |
| Breathing Problem <input type="radio"/> Yes <input type="radio"/> No | Frequent Headaches <input type="radio"/> Yes <input type="radio"/> No | Liver Disease <input type="radio"/> Yes <input type="radio"/> No | Stroke <input type="radio"/> Yes <input type="radio"/> No |
| Bruise Easily <input type="radio"/> Yes <input type="radio"/> No | Genital Herpes <input type="radio"/> Yes <input type="radio"/> No | Low Blood Pressure <input type="radio"/> Yes <input type="radio"/> No | Swelling of Limbs <input type="radio"/> Yes <input type="radio"/> No |
| Cancer <input type="radio"/> Yes <input type="radio"/> No | Glaucoma <input type="radio"/> Yes <input type="radio"/> No | Lung Disease <input type="radio"/> Yes <input type="radio"/> No | Thyroid Disease <input type="radio"/> Yes <input type="radio"/> No |
| Chemotherapy <input type="radio"/> Yes <input type="radio"/> No | Hay Fever <input type="radio"/> Yes <input type="radio"/> No | Mitral Valve Prolapse <input type="radio"/> Yes <input type="radio"/> No | Tonsillitis <input type="radio"/> Yes <input type="radio"/> No |
| Chest Pains <input type="radio"/> Yes <input type="radio"/> No | Heart Attack/Failure <input type="radio"/> Yes <input type="radio"/> No | Osteoporosis <input type="radio"/> Yes <input type="radio"/> No | Tuberculosis <input type="radio"/> Yes <input type="radio"/> No |
| Cold Sores/Fever Blisters <input type="radio"/> Yes <input type="radio"/> No | Heart Murmur <input type="radio"/> Yes <input type="radio"/> No | Pain in Jaw Joints <input type="radio"/> Yes <input type="radio"/> No | Tumors or Growths <input type="radio"/> Yes <input type="radio"/> No |
| Congenital Heart Disorder <input type="radio"/> Yes <input type="radio"/> No | Heart Pacemaker <input type="radio"/> Yes <input type="radio"/> No | Parathyroid Disease <input type="radio"/> Yes <input type="radio"/> No | Ulcers <input type="radio"/> Yes <input type="radio"/> No |
| Convulsions <input type="radio"/> Yes <input type="radio"/> No | Heart Trouble/Disease <input type="radio"/> Yes <input type="radio"/> No | Psychiatric Care <input type="radio"/> Yes <input type="radio"/> No | Veneral Disease <input type="radio"/> Yes <input type="radio"/> No |
| | | | Yellow Jaundice <input type="radio"/> Yes <input type="radio"/> No |

Have you ever had any serious illness not listed above? Yes No

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

Effective date of notice: November 21, 2023
NOTICE OF PRIVACY PRACTICES
Tarrant County College Dental Hygiene Clinic

828 W. Harwood Dr., Hurst TX 76054

817-515-6586

Fax: 817-515-6458

Privacy Officer: Amy Cooper, RDH, TCC Interim Dental Programs Director

amy.cooper@tccd.edu

**THIS NOTICE DESCRIBES HOW YOUR PERSONAL HEALTH INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY**

The Tarrant County College Dental Hygiene Clinic (TCC DHYG Clinic) respects our legal obligation to keep personal health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This Notice describes how we protect your health information and what rights you have regarding it.

TREATMENT AND HEALTH CARE OPERATIONS

The most common reason we use or disclose your health information is for treatment or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; examining your teeth and gums, taking x-rays, prescribing medications, referring you to another doctor or clinic for other health care or services; or getting copies of your personal health information from another professional that you may have seen before us. Health care operations mean those administrative and managerial functions we must do to run our clinic. Examples of how we use or disclose your health information for health care operations are: chart audits and internal quality assurance.

We routinely use your health information inside our clinic for these purposes without any special permission. If we need to disclose your personal health information outside of our clinic for these reasons, we will ask you for special written permission.

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION

In some limited situations, the law allows or requires us to use or disclose your personal health information without your permission. Not all these situations will apply to us; some may never come up at our clinic at all.

Such uses or disclosures are:

- * when a state or federal law mandates that certain health information be reported for a specific purpose; for public health purposes, such as contagious disease reporting, investigation, or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs or medical devices;
- * disclosures to governmental authorities about victims of suspected abuse, neglect, or domestic violence;
- * uses and disclosures for health oversight activities, or investigation of violations of health care laws;
- * disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;
- * disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our clinic; or to report a crime that happened somewhere else;
- * disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations;
- * uses or disclosures for health-related research;
- * uses and disclosures to prevent a serious threat to health or safety;
- * uses or disclosures for specialized government functions, such as for the protection of the president or high-ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service;
- * disclosures of de-identified information;
- * disclosures relating to worker's compensation programs;
- * disclosures of a "limited data set" for research, public health, or health care operations;

Updated 10/29/25 ac

- * incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;
- * disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information;

Unless you object, we will also share relevant information about your care with your family or friends who are helping you with your child's dental hygiene care.

APPOINTMENT REMINDERS

A TCC DHYG Student may call, text or email to remind you of scheduled appointments. The TCC DHYG Clinic Receptionist may call to make an appointment. Unless you tell us otherwise, the student or receptionist will leave you a reminder message on your voicemail device or with someone who answers your phone.

OTHER USES AND DISCLOSURES

We will not make any other uses or disclosures of your health information unless you sign a written "authorization form." The content of an "authorization form" is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if it is your idea for us to send your information to someplace else. Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours. If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization, we cannot make the use or disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing. Send them to the Privacy Officer named at the beginning of this Notice.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

The law gives you many rights regarding your health information.

You can:

- * Ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment) or health care operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. To ask for a restriction, send a written request to the Privacy Officer at the address, fax or email shown at the beginning of this Notice.
- * Ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using email to your personal email address. We will accommodate these requests if they are reasonable, if you want to ask for confidential communications, send a written request to the Privacy Officer at the address, fax or email shown at the beginning of this Notice.
- * Ask to see or to get photocopies of your child's personal health information. By law, there are a few limited situations in which we can refuse to permit access or copying. However, you will be able to review or have a copy of your child's personal health information within 30 days (about 4 and a half weeks) of asking us (or sixty days if the information is stored off-site). You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally available. By law, we can have one 30-day extension of the time for us to give you access or photocopies if we send you written notice of the extension. If you want to review or get photocopies of your personal health information, send a written request to the Privacy Officer at the address, fax or email shown at the beginning of this Notice.
- * Ask us to amend your child's personal health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days (about 2 months) of when you ask us. We will send the corrected information to people who we know got the incorrect information, and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with your child's health information along with any rebuttal statement that we may write. Once your statement of position and/or our rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30-day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your child's health information, send a written request, including your reasons for the amendment, to the Privacy Officer at the address, fax or email shown at the beginning of this Notice.
- * Get a list of the disclosures that we have made of your child's health information within the past six years (or a shorter period if you want). By law, the list will not include disclosures for purposes of treatment or health care operations; disclosures with your authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days (about 2 months)

of receiving it, but by law we can have one 30-day extension of time if we notify you of the extension in writing. If you want a list, send a written request to the Privacy Officer at the address, fax or email shown at the beginning of this Notice.

- * Get additional paper copies of this Notice of Privacy Practices upon request. It does not matter whether you got one electronically or in paper form already. If you want additional paper copies, send a written request to the Privacy Officer at the address, fax or email shown at the beginning of this Notice.

OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your personal health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, and have copies available in our office.

COMPLAINTS

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the Texas Attorney General's Office or the U.S (United States). Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the Privacy Officer at the address, fax or email shown at the beginning of this Notice. If you prefer, you can discuss your complaint in person or by phone.

FOR MORE INFORMATION

If you want more information about our privacy practices, call or visit the Privacy Officer at the address or phone number shown at the beginning of this Notice.

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I reviewed and received a copy of the Tarrant County College Dental Hygiene Clinic's Notice of Privacy Practices.

Date:

Patient name:

Signature:

TARRANT COUNTY COLLEGE
PIT and FISSURE SEALANT COURSE - CONSENT FOR TREATMENT PLAN FORM

COURSE SECTION DNTA-2000 _____ DATE _____

PATIENT NAME _____

COURSE PARTICIPANT NAME _____

This form is to be completed and signed by the DDS only. Please write an "S" in the box corresponding with the teeth that are authorized for pit and fissure sealant placement. Please include the specific surfaces for each authorized tooth (occlusal and/or lingual, buccal groove)

By signing this form, I attest that the approved teeth do not have existing or incipient decay, restorations, or sealants and include at least four (4) posterior teeth including two (2) fully erupted molars

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

This form serves as treatment plan authorization for sealant placement on the above-named patient.

DENTIST _____
Print License No.

DENTIST _____
Signature Date

PATIENT _____
Print

PATIENT _____
Signature Date

COURSE PARTICIPANT _____
Print

COURSE PARTICIPANT _____
Signature Date

This information is confidential, and Tarrant County College Dental Programs will keep any protected health information per HIPAA compliance standards.

**TARRANT COUNTY COLLEGE DISTRICT
PIT and FISSURE SEALANT COURSE
CONSENT FOR TREATMENT FORM
DNTA-2000-_____ DATE _____**

Patient Name _____ Date _____

I agree to be a participant in the Pit and Fissure Sealant Course at Tarrant County College District. As part of that participation, I have received, read, understand, and completed the Consent for Treatment Form and authorize the placement of pit and fissure sealants on the teeth indicated on my prepared treatment plan, in the Pit and Fissure Sealant Course under the direction of approved instructors certified in Pit and Fissure Sealants by the Texas State Board of Dental Examiners.

I understand the treatment I receive during the Pit and Fissure Sealant Course performed in the Dental Hygiene Clinic of Tarrant County College District shall be without liability on the part of Tarrant County College District, its Board of Trustees, faculty, staff, and employees. I understand the treatment being performed is for educational purposes and I release Tarrant County College District to include, but not limited to, the Dental Programs, of any liability pertaining to the treatment received during the Pit and Fissure Sealant Course. I specifically waive any claim I might otherwise have or assert in regard thereto against them or any of them. I understand I am the patient of the dentist listed below and will follow up with any additional dental treatment with that dentist.

I have had the procedure explained to me and had the opportunity to ask questions about the proposed treatment, and they have been fully answered. I hereby give a knowing and voluntary consent for treatment to be performed.

Patient Name (Printed)

Date

Signature of Patient, Parent, or Legal Guardian

Date

Dentist Signature/Date

License No.

Course Participant Performing Procedure (Printed)

Date

Course Participant Performing Procedure (Signature)

Credentials (RDA, RDH, etc.)

POLICY/PROCEDURE ACKNOWLEDGEMENT

This form is to acknowledge that I have reviewed, understand, and agree to the policies and procedures for the Coronal Polishing Certificate Course. Please check each item and sign below. Please submit this form upon course check-in.

I have reviewed the general course information & requirements including:

- Course participants must attend eight (8) hours of training per TSBDE requirements.
- Because course participants will be practicing this skill on a live patient in the clinical setting, all course participants must adhere to the Association for Dental Safety (ADS) (formerly known as OSAP) guidelines including:
 - Professional clinical attire such as scrubs
 - Close-toed shoes (preferably wipeable)
 - No jewelry, nail polish, or artificial nails
 - Long hair pulled back and a scrub cap to cover hair
 - All appropriate PPE during clinical procedures
- Course participants must comply with all course requirements and instructor clinical guidance during the course as the safety of all course participants and patients is paramount. Failure to comply may prevent completion of the course training.
- Course participants must serve as clinician performing the pit & fissure sealant procedure on a patient.
- Course participants will be provided a course Certificate of Completion at the end of the course if all course objectives have been met and verified by the attending instructor.
- Course participants may drop the course for a 100% refund before the start of the course. Contact Business Services @ 817-515-4729 for help if needed. No refunds are issued once the course has started.**

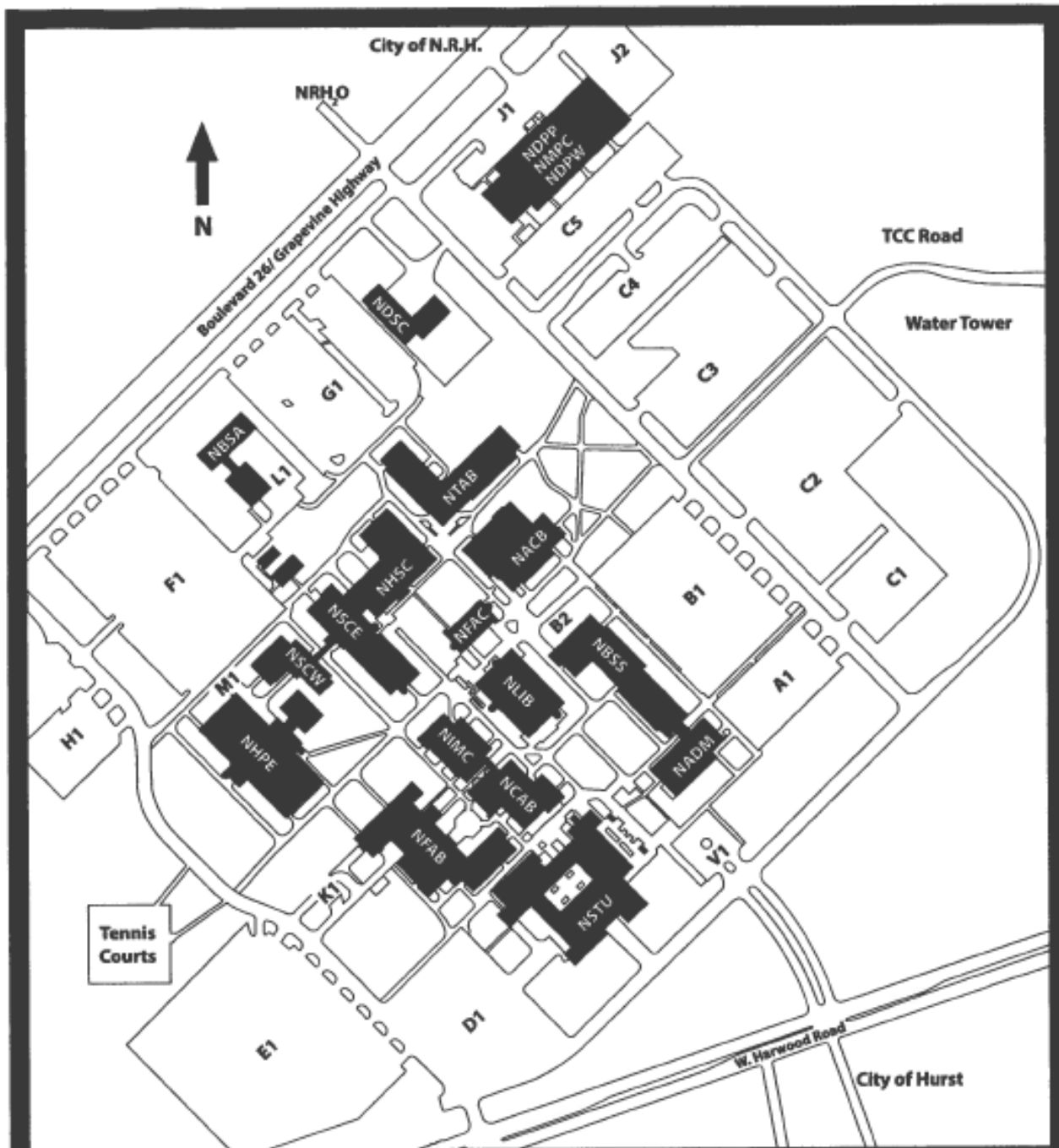
I have provided a copy of the required documents and required forms including:

- Signed letter** from employer (DDS) on practice letterhead verifying at least two (2) years of clinical experience as a dental assistant, per TSBDE requirements, including date of hire.
- Copy of current **CPR Card** basic life support (BLS) CPR certification.
 - Copy of completed **HIPAA/OSHA Compliance Training**
 - Completed **Patient Registration & Medical History** form
 - Completed **TCC Dental Hygiene Clinic notice of Privacy Practices** form
 - Completed **Consent for Treatment Plan** form
 - Completed **Consent for Treatment** form
 - Consent **Procedure Risks and Hazards** form

I have reviewed the required course supplies and am prepared with:

- Protective eyewear
- Scrub cap
- Pen (paper and highlighter (if desired))

Printed Name: _____ Signature: _____ Date: _____



TCC NORTHEAST CAMPUS



**Tarrant
County
College**

Northeast Campus

NADM	Administration Offices (1)	NHPE	Health/Physical Ed. (10)
NACB	Academic Classrooms (7)	NHSC	Health Sciences (15)
NBSA	Building Services (8)	NIMC	Instructional Media Center (6)
NBSS	Business/Social Sciences (2)	NLIB	Library (3)
NCAB	Communication Arts (16)	NMPC	Multi Purpose Classrooms (20)
NDPP	District Physical Plant (20)	NSCE	Science East (9)
NDPW	District Physical Warehouse (20)	NSCW	Science West (9A)
NDSC	District Service Center (11)	NSTU	Student Center/Bookstore/ Cafeteria (4) - Nurse
NFAB	Fine Arts Building (14)	NTAB	Technology & Arts (17)
NFAC	Faculty Offices (5)		