

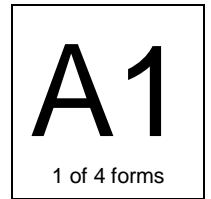
2021

Dental Hygiene Packet

This packet includes the following documents:

1. Online Notice Form - Orientation Slides
2. Patient Disclaimer, Consent & Release Form
3. Post-operative Care Agreement Form (Minimum of 2 copies)
4. Incident Disclaimer Form
5. Medical History Form
6. Dental Hygiene Clinical Procedure Form
7. Dental Hygiene Clinical Periodontal Charting Form
8. Administration of Anesthesia Form (Only needed if a Dentist or Licensed Practitioner is administering your LA)
9. Examination Site Letter (This can be found under 'Documents' on your SRTA profile)

Southern Regional Testing Agency, Inc.
Online Notice Form – Orientation Slides



Exam Site

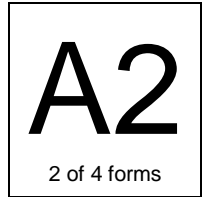
This signed notice must be presented during registration. The online presentation provides details on the requirements for registration and orientation. For your benefit, we strongly suggest you view this presentation.

By signing below, I confirm that I reviewed and understand the online orientation presentation prior to the scheduled registration and examination.

Print Name *Candidate Number*

Signature *Date*

Patient Consent, Disclosure, & Assumption of Responsibility



I authorize the individual referenced below (the "Candidate") to perform the following dental hygiene procedures during the administration by the testing agency (SRTA) of a dental hygiene examination (the "Examination"):

✓ **Partial Oral Prophylaxis and Periodontal Scaling**

Acknowledgement

I understand the following:

- The candidate may not be licensed to perform the above services (the "Services"). **(Cross through this line if the candidate is a licensed dentist.)**
- 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 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.
- I hereby consent to having the Candidate perform each of the Services.

Disclosure of Risks

The Candidate has explained to me the risks and possible complications involved in the procedures the Candidate will perform on me and the nature & purpose of the dental procedure(s) to my satisfaction. My questions regarding the dental procedure(s) have been answered.

Adequacy of Treatment

I understand that the Services 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.

No Treatment by SRTA or School

I understand that SRTA will not be performing any diagnosis or treatment of me. Further, I understand that all the procedures will be performed in spaces under the control of the School but that faculty members, officers, employees and agents of the school will not be present during the performance of the Services. I hereby release the School, its faculty, staff, employees and agents from any and all claims, causes of actions, demands, rights and damages whatsoever arising out of or in connection with the Services performed by the Candidate.

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 where the Examination is located, and any 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. I further consent to disclosure of any information concerning my medical information by SRTA, so long as my name is not associated with the information.

Medical Condition and Medications

I have fully disclosed my current medical conditions and medical history to the best of my knowledge and all medications I am taking. 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. As neither the candidate nor patient is 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 testing agency or school to provide serologic testing, counseling, follow up care or any other health service.

Consent to X-Rays and Photographs

I consent to the taking of appropriate radiographs (X-rays) and the examination of my teeth 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 training and 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 anesthetics by the Candidate.

Assumption of Risk and Release

I release the SRTA, participating dental schools, and their employees and/or agents from any and all responsibility or liability of any nature whatsoever for their acts, 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. I hereby voluntarily assume all risks relating to the Services and the examination, including the risk of injury, loss of teeth and/or death.

I verify that I am not a dentist (licensed or unlicensed), a dental student in the 3rd or 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.

Patient Signature

Date

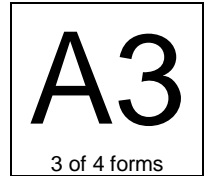
Candidate Initials Only

Candidate Sequential Number

Date

Southern Regional Testing Agency, Inc.

Post-Operative Care Agreement



A separate form must be completed for each patient treated during the examination.

Procedure

Partial Oral Prophylaxis and Periodontal Scaling

Candidate Information

Candidate Sequential # _____	Examination Site _____	Examination Date _____
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Patient Information

Name (Print) _____	Today's Date _____
Address _____	City, State, Zip Code _____

The SRTA Examination is the process for determining if a Dentist/Dental Hygienist has the minimal practical skills necessary to obtain a license to practice Dentistry/Dental Hygiene; therefore, no guarantee can be made that the work performed will be adequate. If you feel you may need additional care as a result of the work performed during the examination, you should visit a licensed Dentist/Dental Hygienist. You may visit a Dentist/Dental Hygienist of your choosing or you may use the referral listed below. **(Note to Candidate: Please complete only one of the sections – A, B, or C – listed in item I. A signature is required under item II – Patient Acceptance.)**

I. Acceptance of Responsibility for Post-Operative Care

- A.** The patient is a "patient of record" at the Dental School and will provide post-operative care as necessary according to the guidelines of the School of Dentistry/Dental Hygiene.

_____	_____
Signature of Authorized School Official	Date

- B.** This is to confirm my willingness to provide any post-operative care required related to treatment rendered on the SRTA dental/dental hygiene examination. It is understood that this agreement expires sixty days following the examination.

_____	_____	_____
Name	License #1	Telephone #
_____	_____	_____
Address	City, State, Zip Code	
_____	_____	
Signature of Provider	Date	

- C.** I will choose my own Dentist/Dental Hygienist if post-operative care is necessary.

_____	_____
Name of Provider	Date

Reason for Post-Operative Care: _____

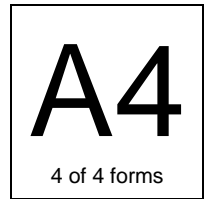
II. Patient Acceptance – I understand and agree to the following:

- Additional treatment related to services rendered during this examination may be required
- Post-operative arrangements specified above
- There may be a fee involved in the post-operative care and I hereby release SRTA and associated testing agencies, and the School of Dentistry/Dental Hygiene where the examination was held from any financial obligation
- The provider listed above has no obligation to provide care if not initiated within sixty (60) days of the examination

_____	_____	_____
Patient Signature	Date	Patient Telephone Number
_____	_____	_____
Legal guardian or Patient Signature (If patient is a minor)	Date	Exam Site

Southern Regional Testing Agency, Inc.

Incident Disclaimer



Exam Site _____

DISCLOSURE STATEMENT AND EXPRESS ASSUMPTION OF RISK FOR ANY DAMAGE FROM (1) EXPOSURE TO BLOODBORNE INFECTIOUS AGENTS SUCH AS HIV, HBV, AND OTHER MICROORGANISMS IN THE BLOOD, (2) EXPOSURE TO ORAL OR RESPIRATORY SECRETIONS, (3) OTHER INJURIES.

The relationship between the Southern Regional Testing Agency (SRTA), the school where the examination is administered ("the school") and you (the candidate or patient) is not an employer/employee relationship. Neither SRTA nor the examination site is responsible for your behavior. As a candidate or patient, you do not qualify as an employee and are not covered under OSHA regulations. You must assume responsibility for any exposure or other incident which may occur.

SRTA and the school cannot, and therefore, do not assume any responsibility or liability for the health status of candidates assistants or patients. If an exposure or other injury occurs during the course of this examination, neither SRTA nor the school assumes any duty or responsibility to you to provide serologic testing, counseling, follow-up care or any other health service. It is your responsibility to assure that you see a licensed health care professional and initiate appropriate management and follow-up care.

LIMITATION OF LIABILITY AND INDEMNITY AGREEMENT

I, the undersigned, state that I have read and understood the above disclosure statement and express assumption of risk. I agree that SRTA and the school are not responsible for the prevention or management of any of the incidents listed above. I agree to release and discharge SRTA for any liability or personal injury which may occur to me, unless actively committed by SRTA. I agree to release and discharge the school for any liability or injury that may occur to me unless actively committed by school personnel. I further understand that SRTA and the school have no responsibility or duty to provide medical evaluation treatment, counseling, follow-up care, or any type of compensation for any of the incidents listed above. I also agree to indemnify and hold SRTA and the school harmless for any occurrence under this agreement, including SRTA's and the school's attorneys' fees, costs and expenses, should a claim be made against them.

Candidate: Printed Name & Candidate Sequential Number

Patient: Printed Name

Candidate: Signature

Patient: Signature

Candidate: Date Signed

Patient: Date Signed

Southern Regional Testing Agency, Inc.

Dental Hygiene Patient Medical History

B

1 of 1 form

Candidate # _____		Cubicle # _____	
Will this patient be shared with another candidate today? <input type="checkbox"/> Yes <input type="checkbox"/> No		Sharing patient with Candidate # _____	
Patient Name _____		Date Form Completed _____	
Birthdate _____	Weight _____	Blood Pressure _____ <small>Required – must be taken day of examination</small>	Date/Time Taken _____ <small>CFM confirms BP taken day of examination</small>
Instructions to Patient			CFM Pin _____

Answer the following questions as completely and accurately as possible. All Information is CONFIDENTIAL. Please circle "YES" or "NO" to all questions and write in your answers as appropriate.

1. **YES NO** Are you under the care of a physician at this time?
If yes, for what condition? _____
2. The name, address & telephone of my physician is _____
3. My last complete physical examination was on _____
4. **YES NO** Has a physician treated you in the past six months?
If yes, for what condition? _____
5. **YES NO** Have you been hospitalized or have a serious illness or skin condition within the last five years?
If yes, please specify: _____
6. **YES NO** Are you allergic or had any adverse reaction to any medicine, drugs, local anesthetics, LATEX or other substances?
If yes, please specify: _____
7. **YES NO** Do you now or have you ever smoked cigarettes or used tobacco products?
If yes, please specify: # of packs/day: _____ # of years: _____
8. Do you have or have you had any of the following diseases/problems? Please explain "YES" answers below. **"YES" answers in the shaded area require a written letter from the patient's physician giving permission to participate in this exam.**

If YES, MD written clearance required	A. YES NO	Angina/chest pain, shortness of breath	Q. YES NO	Emotional/mental health disorder (anxiety, depressions, bipolar)
	B. YES NO	Heart attack Date: _____	R. YES NO	Liver disease (hepatitis A or B/jaundice/cirrhosis)
	C. YES NO	Heart surgery Date: _____	S. YES NO	Hives, itching or skin rash
	D. YES NO	Stroke Date: _____	T. YES NO	Sexually transmitted disease(s)
	E. YES NO	Congestive heart failure	U. YES NO	Stomach or duodenal ulcers
	F. YES NO	Coronary artery or other heart disease	W. YES NO	Tuberculosis or pertussis
	G. YES NO	Arteriosclerosis/coronary occlusion	X. YES NO	Congenital heart disease
	H. YES NO	Epilepsy/seizures/convulsions	Y. YES NO	Pacemaker
	I. YES NO	Valve damage following heart transplant	Z. YES NO	Cancer/chemo/radiation therapy
	J. YES NO	Infective endocarditis (heart infection)	AA. YES NO	Implanted cardio-defibrillator
	K. YES NO	Kidney/renal disease	BB. YES NO	Immune suppression or deficiency
	L. YES NO	HIV positive/AIDS	CC. YES NO	Artificial/prosthetic joint replacement (knee or hip)
	M. YES NO	Hepatitis C	DD. YES NO	Artificial/prosthetic heart valves Date: _____
	N. YES NO	Abnormal bleeding, bruise or history of transfusion. Taking aspirin or blood thinner?	EE. YES NO	Alcohol Abuse (alcohol rehabilitation) Date: _____
O. YES NO	Lung/respiratory condition (asthma, bronchitis, emphysema)	FF. YES NO	Drug abuse (cocaine, methamphetamines, heroin, crack) or drug rehabilitation	
P. YES NO	Diabetes	GG. YES NO	High blood pressure	

Turn Page Over

Candidate # _____	Cubicle # _____
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Letter	Explanation for "YES" answers in question 8

9. YES NO Have you had surgery or x-ray treatment for a tumor, growth or other condition of your head or neck?
If yes, please list:

10. YES NO Do you have any other diseases, conditions, or problems that have not been listed? If yes, please explain:

Other Conditions	Explanation

11. YES NO Are you taking or have you ever taken any medications, (examples below), either orally or by injection, for osteoporosis, osteopenia, or bone loss due to aging OR lung cancer, breast cancer, prostate cancer, colorectal cancer, wet macular degeneration, Paget's Disease, or multiple myeloma?

Examples: Fosamax® (alendronate); Boniva® (ibandronate); Actonel® (risedronate); Reclast® yearly injection (zoledronic acid); Aredia® (pamidronate); Zometa® (zoledronic acid); Bonefos® (clodronate); Avastin® (bevacizumab); Erbitux® (cetuximab); Herceptin® (trastuzumab)?

If so, please list the appropriate medication(s) below:

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12. Please list any **premedication, medications, pills, or drugs with dosage** which you are taking both prescription and non prescription. **(Must be completed the DAY OF THE EXAMINATION)**

	Medication	Reason Prescribed
1.		
2.		
3.		
4.		
5.		

13. WOMEN ONLY

YES NO Are you pregnant or is there any possibility that you might be pregnant?
If yes, when is your expected due date? _____

YES NO Are you currently breastfeeding?

AMERICAN SOCIETY OF ANESTHESIOLOGY (ASA) CLASSIFICATION

ASA I: Normal health patient

ASA II: Patient with mild systemic disease; no function limitation – e.g., smoker with well-controlled hypertension

ASA III: Patient with severe systemic disease; definite functional impairment – e.g., diabetes mellitus (DM) and angina pectoris with relatively stable disease, but requiring therapy

CLASS

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DENTAL HYGIENE CANDIDATES: Any item on the Medical History with a "YES" response, in questions #8A THROUGH #8M require medical clearance from a licensed physician. The medical clearance must include the physician's name, address, and phone number. Attach letter to this form to turn in on the day of the examination.

I certify that I have read and understood the above. I acknowledge that I have answered these questions accurately and completely. I will not hold the testing agency responsible for any action taken or not taken because of errors I may have made when completing this form.

Patient Signature

Date

Candidate Initials Only

Date

Southern Regional Testing Agency, Inc.

Dental Hygiene Procedure Form

C1

1 of 2 forms

Section 1: General Information

Candidate # _____ Cubicle # _____ Exam Site _____ Date _____

Will this patient be shared with another candidate today? Yes No Sharing patient with Candidate # _____

Section 2: Medical Clearance Examiner Use Only | CFM PIN _____ (Pt. is cleared for treatment)

Section 3: Selection of Teeth for Calculus Removal

Primary Quadrant Submission

Circle Primary Quadrant Include this quadrant's 3rd molar?

UR UL Yes No
LR LL

Secondary Quadrant Submission

Circle Secondary Quadrant Include this quadrant's 3rd molar?

UR UL Yes No
LR LL

Section 4: Selection Assignment Examiner Use Only | DO NOT WRITE IN THIS SECTION

After check-in, the final assignment is entered here by the examiners. All surfaces of all teeth in this assignment must be free of remaining calculus, plaque, and stain for the final evaluation phase of the examination. No other areas of the patient's mouth will be evaluated.

Quadrant to treat _____

Additional teeth to treat _____

Section 5: Anesthesia Record Complete all information except quantity prior to check-in.

Type(s) of injections planned _____ Name of anesthetic & vasoconstrictor _____

Quantity (# of carpules/cartridges administered; complete after all injections given) _____

Candidate number OR signature of qualified practitioner _____

Section 6: Periodontal Assessment

Do not complete this section until after check-in. Enter the probing depth in millimeters for the teeth surfaces assigned in this section.

Posterior Tooth # _____ ML _____ L _____ DL _____ Anterior Tooth # _____ ML _____ L _____ DL _____

Section 7: Calculus Detection

Do not complete this section until after check-in. Is any type of calculus present? Circle "Yes" or "No" for the four surfaces of each tooth assigned below.

Tooth # _____ Mesial Yes No Distal Yes No Facial Yes No Lingual Yes No

Tooth # _____ Mesial Yes No Distal Yes No Facial Yes No Lingual Yes No

Tooth # _____ Mesial Yes No Distal Yes No Facial Yes No Lingual Yes No

Pre-Treatment

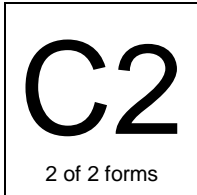
Examiner #1:	O	P	T	I	O	N	A	L	STAMP REQUIRED
Examiner #2:	O	P	T	I	O	N	A	L	
Examiner #3:	O	P	T	I	O	N	A	L	
FINISH TIME:									

Post-Treatment

Examiner #1:	O	P	T	I	O	N	A	L	STAMP REQUIRED
Examiner #2:	O	P	T	I	O	N	A	L	
Examiner #3:	O	P	T	I	O	N	A	L	
EXAM COMPLETED (CFM PIN)									<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

Southern Regional Testing Agency, Inc.

Dental Charting Form



Section 1: General Information

Candidate # _____ Cubicle # _____ Exam Site _____ Date _____

Patient Name _____

Will this patient be shared with another candidate today? Yes No Sharing patient with Candidate # _____

Section 2: Medical Clearance Examiner Use Only | CFM PIN _____ (Pt. is cleared for treatment)

CFM – List any relevant health issues _____

Section 3: Selection of Teeth for Calculus Removal

Primary Quadrant Submission

Circle Primary Quadrant Include this quadrant's 3rd molar?

UR UL Yes No
LR LL

Secondary Quadrant Submission

Circle Secondary Quadrant Include this quadrant's 3rd molar?

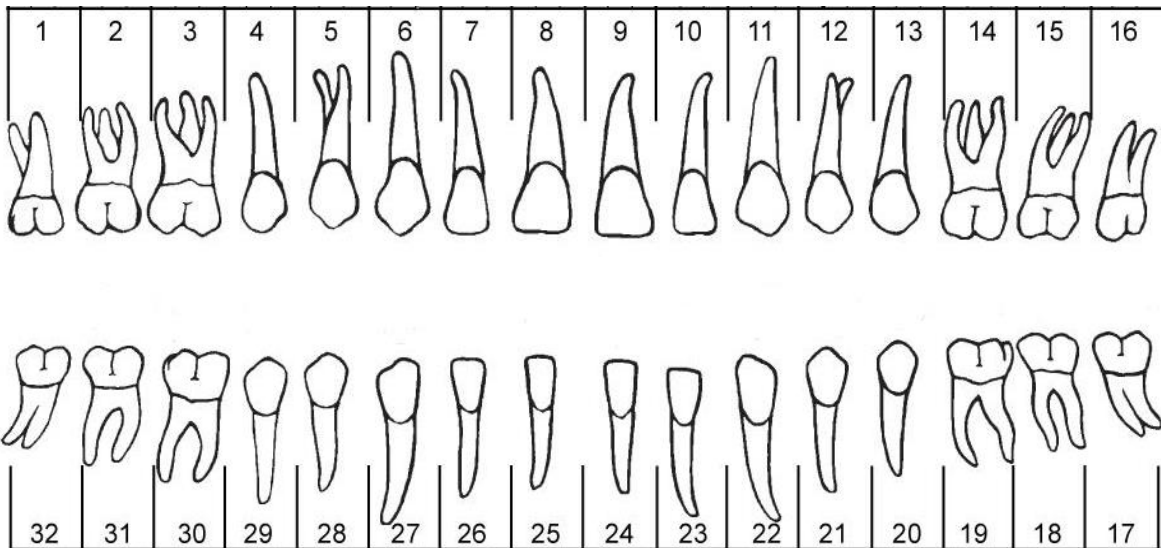
UR UL Yes No
LR LL

Section 4: Candidate Comments to Examiners

Section 5: Dental Charting

Chart the following items prior to the examination:

- Missing teeth – Cross (X) out entire tooth area
- Implants – Cross (X) through tooth and change the tooth number to "I"
- Impacted/Unerupted – Circle the entire tooth, root, and tooth number
- Partially erupted – Replace the tooth # with "PE"
- Deciduous tooth – Replace the tooth # with the tooth letter
- Retained root tip – Cross (X) through the crown, circle the root, and place the tooth # with "RT"
- Permanent bridge pontic – Cross (X) through tooth and change tooth number to



Section 6: Examiner Comments

For examiner use only. Candidates do not write in this section

Examiner – please enter PIN after comments

Southern Regional Testing Agency, Inc.

Administration of Anesthesia by a Licensed Practitioner

Exam Site _____ Exam Date _____

I, _____, accept responsibility for the anesthesia related emergencies and anesthesia related postoperative complications affecting the patients to whom I have administered anesthesia. I am aware that it is recommended that I remain in the examination site during the candidates' treatment of the patient and that I give the patient information on how to contact me, if necessary, after the exam.

I will be administering anesthesia to the patients of the following candidate(s) (use back of this form if space is needed):

Print Name _____ Telephone Number _____

Address _____ City _____ State _____ Zip Code _____

You must also provide on the day of the exam:

1. Photo ID
2. Copy of dental or dental hygiene license from the state where the exam is held
3. Copy of local anesthesia permit from state where the exam is held, if you are a dental hygienist
4. Copy of verification of current liability insurance