

Oregon Health Licensing Agency

Board of Denture Technology



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TRAINEE REGISTRATION APPLICATION

1. Trainee Information

APPLICANT NAME		LAST	FIRST	MIDDLE INTIAL
RESIDENTIAL ADDRESS				
CITY		STATE	ZIP	
MAILING ADDRESS (IF DIFFERENT FROM RESIDENTIAL ADDRESS)				
CITY		STATE	ZIP	
HOME TELEPHONE	BUSINESS TELEPHONE		E-MAIL	
GENDER <input type="checkbox"/> Female <input type="checkbox"/> Male		BIRTHDATE / /	SOCIAL SECURITY NUMBER (REQUIRED)	

2. Trainer Information

TRAINER NAME		LAST	FIRST	MIDDLE INTIAL
TRAINER ADDRESS				
CITY		STATE	ZIP	
HOME TELEPHONE	BUSINESS TELEPHONE		E-MAIL	
TRAINEE STARTING DATE		PROJECTED ENDING DATE		

3. Trainee – Read and Sign Below

I agree to fulfill the requirements of my training by:

1. Performing the activities required by rule and as described on the Certification of Work Experience.
2. Developing my clinical and laboratory skills by accepting the guidance and assistance provided to me by my supervisor.
3. Notifying the Health Licensing Agency in writing within 5 working days of any problems encountered during my training, or if my training is interrupted or terminated for any reason; and
4. Responding to request for information from the Health Licensing Agency regarding the process of my training.

Trainee Signature: _____ Date: _____

4. Trainer – Read and Sign Below

I agree to fulfill the requirements of a trainer by:

1. Assigning activities required by rule and as described on the **Certificate of Work Experience** to the Inter for _____ hours per week for a total of _____ hours during the period for internship.
2. Providing supervision, guidance, and assistance to the intern, increasing the complexity of assignments quarterly to allow the intern to develop clinical and laboratory skills necessary for independent or shared practice;
3. Notifying the Health Licensing Agency in writing within five (5) working days of any problems encountered during this internship agreement, or if the internship is interrupted or terminated for any reason;
4. Responding to requests for information from the Health Licensing Agency regarding the progress of the intern.
5. Completing the **Certificate of Work Experience** form when a minimum of 1,000 hours of training is completed or the internship is terminated for any reason.
6. The facility where the training will occur is in compliance with all provisions of OAR 331 Division 420 Practice Standards.
7. Limiting supervision to two (2) interns at any given time.
8. I have been practicing as a licensed dentist or licensed denturist for at least three (3) years, according to OAR 331-410-0000(4)(b).

Trainee Signature: _____ Date: _____

For Official Use Only- Do Not Write in this Section

Initials _____ OTC

Method of Payment: Cash Discover Visa Master Card Check Money Order Purchase Order

Trainee Registration Application Checklist

- Registration is completed, signed and dated.
- Submit the \$200 fee with the Trainee registration application.