



DENTAL ASSISTANT VERIFICATION

Candidate Name: _____ I.D.#: _____

Exam Site: _____ Exam Date: _____

Western Regional Examining Board, an Arizona non-profit corporation ("WREB"), is a national dental and dental hygiene testing agency required to test candidates' clinical skills for the states that accept the results of the WREB exams.

The relationship between WREB, the school where the exam is administered and the dental candidate is strictly a contract service and not an employer/employee relationship. You are working as an assistant employed by the dental candidate taking the exam. As your employer, the candidate maintains responsibility for your compliance with all regulations mandated to employees by the Occupational Safety and Health Administration (OSHA).

WREB does not assume responsibility or liability for the health status of you, your dentist or the patient(s). If an injury or exposure to infectious agents occurs during the course of this examination, neither WREB nor the school assumes any responsibility to provide follow-up care. It is the candidate's 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

You hereby expressly agree to assume the risk for an exposure or injuries of any kind that occur before, during or after the WREB examination. You agree to indemnify WREB against and hold WREB harmless from any and all losses, claims, demands, damages, assessments, costs and expenses (including reasonable attorneys' fees) of every kind, nature or description resulting from, arising out of or relating to your health care, status or condition before, during or after the examination.

REMINDER: The use of unauthorized assistants is grounds for immediate dismissal from the exam for the candidate, resulting in disciplinary action and possible denial of a license to practice dentistry. An individual who serves as an unauthorized assistant may be subject to disciplinary action in the state in which licensed/certified.

The following information must be completed:

By signing below, I hereby confirm that I am qualified in accordance with the Candidate Guide and have read and understand the Disclosure Statement, Limitation of Liability and Indemnity Agreement above:

Assistant Printed Name (Operative)	Signature	Address	City, State, Zip
Assistant Printed Name (Perio)	Signature	Address	City, State, Zip
Assistant Printed Name (Additional)	Signature	Address	City, State, Zip

- No Operative Assistant was used.
- No Periodontal Treatment Assistant was used.

CANDIDATE: I verify that I have confirmed the accuracy of the information contained on this form.

Candidate Signature