



## DENTAL ASSISTANT VERIFICATION

Candidate Name: \_\_\_\_\_ I.D.#: \_\_\_\_\_

Exam Site: \_\_\_\_\_ Exam Date: \_\_\_\_\_

**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 DENTAL INJURIES.**

WREB is a national dental and dental hygiene testing agency required to test candidates' clinical skills for the states subscribing to our service. The relationship between WREB, the school where the exam is administered and the dental candidate is 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 and the school cannot, and therefore, do not assume any responsibility or liability for the health status of you, your dentist or the patient(s). If any exposure or other injury occurs during the course of this examination, neither WREB nor the school assumes any duty or responsibility to you to provide serologic testing, counseling, follow-up or any other health service. 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***

I, the undersigned, state that I have read and understood the above disclosure statement and express assumption of risk. I agree that WREB and the school are not responsible for the prevention or management of any of the incidents listed above. I agree to release and discharge WREB and the school for any liability or damage which may occur to me, unless expressly committed by WREB or school personnel. I understand that WREB and the school have no responsibility or duty to provide medical evaluation, treatment, counseling, follow-up, or any type of compensation for any of the incidents listed above.

**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 and Limitation of Liability above:

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

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Candidate Signature