



**DENTAL ASSISTING / ORTHODONTIC ASSISTING PROGRAM  
ENROLLMENT AGREEMENT**

**ADMISSION REQUIREMENTS**

ILLINOIS DENTAL CAREERS APPLICANTS MUST BE 18 YEARS OR OLDER BY THE TIME OF THEIR PROGRAM COMPLETION.

**STUDENT INFORMATION**

FIRST NAME \_\_\_\_\_ LAST NAME \_\_\_\_\_

STREET ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

CELL PHONE NUMBER \_\_\_\_\_ WORK \_\_\_\_\_

E-MAIL ADDRESS \_\_\_\_\_

DRIVER'S LICENSE/ID NUMBER \_\_\_\_\_

STUDENT ID NUMBER: \_\_\_\_\_ ADMISSION DATE: \_\_\_\_\_

SOCIAL SECURITY NUMBER \_\_\_\_\_ EMERGENCY CONTACT \_\_\_\_\_

RELATIONSHIP \_\_\_\_\_ PHONE NUMBER \_\_\_\_\_

**PROGRAM INFORMATION**

**SELECT A PROGRAM**

- DENTAL ASSISTING PROGRAM (10 WEEKS )
- ORTHODONTIC ASSISTING PROGRAM (8 WEEKS - 40 CLOCK HOURS)

**SELECT A SESSION**

- WINTER 2021
- SPRING 2021
- SUMMER 2021
- FALL 2021

SESSION START DAY / DATE \_\_\_\_\_ SESSION END DAY/DATE \_\_\_\_\_

CLASS START TIME \_\_\_\_\_ CLASS END TIME \_\_\_\_\_

**SELECT A LOCATION**

- HARWOOD HEIGHTS
- HOMEWOOD
- MUNDELEIN
- ROCKFORD



**PROGRAM / COURSE OBJECTIVES: PRODUCE WORK-READY DENTAL ASSISTANTS**

**DENTAL ASSISTING PROGRAM DESCRIPTION:** 20 MODULES/2.5 HOURS EACH, OFFERED TWICE A WEEK IN THE EVENING (PLEASE, REFER TO ACADEMIC CALENDAR, POSTED IN SCHOOL CATALOG, FOR DETAILS), EACH INCLUDE THEORETICAL AND CLINICAL COMPONENTS, COVERING DENTAL AND ORAL ANATOMY AND PHYSIOLOGY, CHAIRSIDE ASSISTING, RADIOLOGY, IMPRESSIONS, INSTRUMENT IDENTIFICATION, RESTORATIVE MATERIALS AND PROCEDURES, LAB MATERIALS AND TECHNIQUES. THE PROGRAM ALSO INCLUDES CORONAL POLISHING, PIT AND FISSURE SEALANTS PLACEMENT, INFECTION CONTROL, STERILIZATION, AND ASSISTING IN DENTAL SPECIALTIES.

**ORTHODONTIC ASSISTING PROGRAM DESCRIPTION:** 10 MODULES/2.5 HOURS EACH, OFFERED ON SATURDAYS (PLEASE, REFER TO THE ACADEMIC CALENDAR, POSTED IN SCHOOL CATALOG, FOR DETAILS), FOLLOWED BY A 40-HOUR ORTHODONTIC INTERNSHIP. INCLUDE THEORETICAL AND CLINICAL COMPONENTS, COVERING ADVANCED DENTAL AND ORAL ANATOMY AND PHYSIOLOGY, BASIC TO ADVANCED ORTHODONTIC CHAIRSIDE ASSISTING, ORTHODONTIC MATERIALS AND SUPPLIES, INSTRUMENTS AND PROCEDURES, APPLIANCES, INVISALIGN, RADIOLOGY, AND IMPRESSIONS.

40-HOUR ORTHODONTIC INTERNSHIP MUST BE COMPLETED WITHIN ONE MONTH FROM THE DATE WHEN THE 10 ORTHODONTIC MODULES HAVE BEEN FINISHED. ORTHODONTIC INTERNSHIP CAN BE COMPLETED AT ANY OF THE FOUR ORTHODONTIC CLINICS LISTED IN THE ACADEMIC CATALOG. STUDENTS CAN ROTATE BETWEEN THE CLINICS TO FULFILL THE INTERNSHIP REQUIREMENT IN A TIMELY MANNER. INTERNSHIP FORMS MUST BE SIGNED AT THE END OF EACH INTERNSHIP DAY BY ORTHODONTIC ASSISTANT AND CLINIC MANAGER. INTERNSHIP FORMS MUST BE EMAILED TO PROGRAM COORDINATOR ([ILDENTALCAREERS@GMAIL.COM](mailto:ILDENTALCAREERS@GMAIL.COM)) AT THE END OF EVERY OTHER WEEK OF THE INTERNSHIP.

**ATTENDANCE POLICY:** ILLINOIS DENTAL CAREERS OPERATES ON A ROLLING ADMISSION BASIS, WHERE STUDENTS CHOOSE THE START AND END DATES OF THEIR PROGRAMS, AS WELL AS THEIR OWN PACE OF STUDYING. THE ONLY REQUIREMENT FOR STUDENTS IS TO COMPLETE AT LEAST ONE PROGRAM MODULE EVERY TWO WEEKS IN ORDER TO STAY ACTIVE IN THE PROGRAM. IF THE STUDENTS MISS A MODULE DURING THE WEEK, THEY CAN WAIT UNTIL THIS MODULE IS OFFERED AGAIN DURING THE NEXT ACADEMIC CALENDAR CYCLE AND TAKE IT AT THAT TIME.

**TUITION AND FEES:**

DENTAL ASSISTING PROGRAM: **\$3,400**

ORTHODONTIC ASSISTING PROGRAM: **\$1875**

DENTAL AND ORTHODONTIC ASSISTING PROGRAMS COMBINED: **\$4642** INSTEAD OF \$5275  
(12% SAVINGS)

5% DISCOUNT IF STUDENT PAYS TUITION IN FULL UPON SIGNING THIS AGREEMENT

ALL PAYMENT PLANS WILL REQUIRE CREDIT CARD.



**PROGRAM COMPLETION REQUIREMENTS**

- STUDENTS MUST COMPLETE ALL ASSIGNED MODULES IN THEIR PROGRAMS.
- STUDENTS MUST ATTAIN AT LEAST A 70% FINAL GRADE IN THEIR PROGRAMS.

**TUITION INCLUDES ALL OF THE FOLLOWING:**

1. Lectures: handouts and instructional materials
2. Training materials and dental supplies
3. Access to state-of-the-art technology
4. Dental/Orthodontic Assisting Certificate
5. Dental Assistant’s Pin
6. Clinical fees
7. Access to Google Classroom

\*Please note that students are responsible for their scrubs and gym shoes/clogs to wear in class.

**PAYMENT PLANS:**

DENTAL ASSISTING PROGRAM PAYMENT PLAN: \$1000 DOWN PAYMENT UPON SIGNING THIS AGREEMENT, FOLLOWED BY 8 WEEKLY PAYMENTS OF \$300.

ORTHODONTIC ASSISTING PAYMENT PLAN: \$750 DOWN PAYMENT UPON SIGNING THIS AGREEMENT, FOLLOWED BY 6 WEEKLY PAYMENTS OF \$187.50.

DENTAL AND ORTHODONTIC ASSISTING PROGRAMS COMBINED, PAYMENT PLAN: \$1000 DOWN PAYMENT UPON SIGNING THIS AGREEMENT, FOLLOWED BY 10 WEEKLY PAYMENTS OF \$364.20

**FINANCIAL AID:**

ILLINOIS DENTAL CAREERS DOES NOT OFFER FINANCIAL AID FOR TUITION ASSISTANCE.

**FINANCIAL ARRANGEMENTS:**

**TOTAL DUE** \_\_\_\_\_

**CHOOSE CREDIT CARD** (PAID IN FULL)

FULL TUITION INCLUDES ALL BOOKS, SUPPLIES AND ANY MISCELLANEOUS EXPENSES, DOES NOT INCLUDE SCRUBS AND GYM SHOES/CLOGS TO WEAR IN CLASS

**TUITION PAYMENT PLAN (all payment plans require automatic payments)**

\$ \_\_\_\_\_ DOWN PAYMENT, FOLLOWED BY \_\_\_\_\_ WEEKLY PAYMENTS OF \$ \_\_\_\_\_



**CREDIT CARD**

CREDIT CARD NUMBER \_\_\_\_\_

EXP. DATE \_\_\_\_\_ CVV \_\_\_\_\_

CARDHOLDER'S NAME: \_\_\_\_\_

CARDHOLDER'S SIGNATURE: \_\_\_\_\_

I, \_\_\_\_\_, PROVIDE MY CONSENT TO ILLINOIS DENTAL CAREERS TO CHARGE MY CREDIT CARD WEEKLY FOR THE AMOUNT OF \$\_\_\_\_\_ UNTIL THE BALANCE OF \$\_\_\_\_\_ IS PAID OFF IN FULL. I UNDERSTAND THAT ANY BANK OR NSF FEES CHARGED TO IDC WILL BE PASSED ON TO MY ACCOUNT. THE FEES ARE AS FOLLOWS: \$25 FOR DECLINED CREDIT CARDS AND \$50 FOR DECLINED BANK ACCOUNTS. ANY DELINQUENT ACCOUNTS WILL BE SENT TO COLLECTIONS.

**PRINTED NAME** \_\_\_\_\_ **SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_

**REFUND/CANCELLATION POLICY:**

- ILLINOIS DENTAL CAREERS SHALL, WHEN A STUDENT GIVES A WRITTEN NOTICE OF CANCELLATION, PROVIDE A REFUND IN THE AMOUNT OF AT LEAST THE FOLLOWING:
- WHEN A NOTICE OF CANCELLATION IS GIVEN BEFORE MIDNIGHT OF THE FIFTH BUSINESS DAY AFTER THE DATE OF ENROLLMENT BUT PRIOR TO THE FIRST DAY OF CLASS ATTENDANCE BY THE STUDENT, 100% OF TUITION, AND ANY OTHER CHARGES SHALL BE REFUNDED TO THE STUDENT;
- WHEN A NOTICE OF CANCELLATION IS GIVEN AFTER MIDNIGHT OF THE FIFTH BUSINESS DAY FOLLOWING THE DATE OF ENROLLMENT BUT PRIOR TO THE CLOSE OF BUSINESS ON THE STUDENT'S FIRST DAY OF CLASS ATTENDANCE, THE SCHOOL MAY RETAIN NO MORE THAN THE APPLICATION REGISTRATION FEE WHICH MAY NOT EXCEED \$150 OR 50% OF THE COST OF TUITION, WHICHEVER IS LESS;
- APPLICANTS NOT ACCEPTED BY THE SCHOOL SHALL RECEIVE A REFUND OF ALL TUITION AND FEES PAID WITHIN 30 CALENDAR DAYS AFTER THE DETERMINATION OF NON-ACCEPTANCE IS MADE; ● DEPOSITS OF DOWN PAYMENTS SHALL BECOME PART OF THE TUITION;
- THE SCHOOL SHALL MAIL A WRITTEN ACKNOWLEDGEMENT OF A STUDENT'S CANCELLATION OR WRITTEN WITHDRAWAL TO THE STUDENT WITHIN 15 CALENDAR DAYS OF THE POSTMARK DATE OF NOTIFICATION. SUCH WRITTEN ACKNOWLEDGEMENT IS NOT NECESSARY IF A REFUND HAS BEEN MAILED TO THE STUDENT WITHIN THE 15 CALENDAR DAYS;
- ALL STUDENT REFUNDS SHALL BE MADE BY THE SCHOOL WITHIN 30 CALENDAR DAYS FROM THE DATE OF RECEIPT OF THE STUDENT'S CANCELLATION;
- STUDENTS MUST COMPLETE AT LEAST ONE MODULE EVERY TWO WEEKS TO STAY IN THE PROGRAM. NOT COMPLETING AT LEAST ONE MODULE EVERY TWO WEEKS SHALL CONSTITUTE CONSTRUCTIVE NOTICE OF CANCELLATION TO THE SCHOOL. FOR PURPOSES OF CANCELLATION, THE DATE OF CANCELLATION SHALL BE THE LAST DAY OF ATTENDANCE.



**SHOULD THE STUDENT’S ENROLLMENT BE TERMINATED OR SHOULD THE STUDENT WITHDRAW FOR ANY REASONS, ALL REFUNDS WILL BE MADE ACCORDING TO THE FOLLOWING REFUND SCHEDULE:**

Number of Modules Completed	Refund Amount (% of Tuition)
1	100% minus the registration fee of \$150
2	90% tuition
3	80% tuition
4	70% tuition
5	60% tuition
6	50% tuition
7	40% tuition
8	30% tuition
9	20% tuition
10	10% tuition
11 or more	0% tuition

**NOTICE TO STUDENT**

1. Do not sign this agreement before you have read it or if it contains any blank spaces.
2. This agreement is a legally binding document and is only binding when the agreement is accepted, signed, and dated by the authorized official of the school or the admissions officer at the school’s principal place of business. Read all pages of this contract before signing.
3. You are entitled to an exact copy of the agreement and any disclosure pages you sign.
4. This agreement and the school catalog constitute the entire agreement between the student and the school.
5. Any changes in this agreement must be made in writing and shall not be binding on either the student or the school unless such changes have been approved in writing by the authorized official of the school and by the student or the student’s parent or guardian. All terms and conditions of the agreement are not subject to amendment or modification by oral agreement.
6. The school does not guarantee the transferability of credits to another school, college, or university. Credits or coursework are not likely to transfer; any decision on the comparability, appropriateness, and applicability of credit and whether credit should be accepted is the decision of the receiving institution.



## STUDENT'S RIGHT TO CANCEL

The student has the right to cancel the initial enrollment agreement until midnight of the 5th business day after the student has been accepted by the school. If the right to cancel is not given to any prospective student at the time the agreement is signed, then the student has the right to cancel the agreement at any time and receive a refund on all monies paid to date within 30 days of cancellation. Cancellations should be delivered in writing to the school management.

## STUDENT ACKNOWLEDGMENTS

### Student Initials

- I hereby acknowledge receipt of the school's catalog, which contains information describing programs offered, and equipment or supplies provided. The school catalog is included as part of this enrollment agreement and I acknowledge that I have received a copy of this catalog.
- I have carefully read and received an exact copy of this enrollment agreement.
- I understand that the school may terminate my enrollment if I fail to comply with attendance, academic, and financial requirements or if I fail to abide by established standards of conduct, as outlined in the school catalog. While enrolled in the school, I understand that I must maintain satisfactory academic progress as described in the school catalog and that my financial obligation to the school must be paid in full before a certificate or credential may be awarded.
- I hereby acknowledge that the school has made available to me all required disclosure information listed under the Consumer Information section of this Enrollment Agreement.
- I understand that the school does not guarantee transferability of credit and that in most cases, credits or coursework are not likely to transfer to another institution. In cases where transferability is guaranteed, Illinois Dental Careers must provide me copies of transfer agreements that name the exact institution(s) and include agreement details and limitations.
- I understand that the school does not guarantee job placement to graduates upon program completion.
- I understand that complaints, which cannot be resolved by direct negotiation with the school in accordance with its written grievance policy, may be registered in writing with the Illinois Board of Higher Education, Division of Private Business and Vocational Schools. Information about the complaint may be submitted online through the IBHE website (<http://complaints.ibhe.org/>) Additional information regarding the complaint process can be obtained by contacting the Board at 1 N. Old State Capitol Plaza, Suite 333, Springfield, IL 62701, Phone Number: (217) 782-2551, Fax Number: (217) 782-8548.
- The student acknowledges receiving a copy of this completed agreement, the school catalog, and written confirmation of acceptance prior to signing this contract. The student by signing this contract acknowledges that he/she has read this contract, understands the terms and conditions, and agrees to the conditions outlined in this contract. It is further understood that this agreement supersedes all prior or contemporaneous verbal or written agreements and may not be modified without the written agreement of the student and the School officials. The student and the school will retain a copy of this agreement.



**INSTITUTIONAL DISCLOSURES**

- 1. The number of students who were admitted to the Dental Assisting Program as of July 1 of this reporting period: 12
- 2. The number of students who were admitted to the Orthodontic Assisting Program as of July 1 of this reporting period: 28
- 3. The number of additional students who were admitted in the Dental/Orthodontic Assisting Programs during the next 12 months and classified in one of the following categories: a) Dental Assisting Program, new starts: 12. Orthodontic Assisting Program, new starts: 28. b) Re-enrollments: 0. c) Transfers into the program from other programs at the school: 0.
- 4. The total number of students admitted in the Dental Assisting Program during the 12-month reporting period: 12. The total number of students admitted in the Orthodontic Assisting Program during the 12-month reporting period: 28.
- 5. The number of students enrolled in the programs during the 12-month reporting period who: a) Transferred out of the program or course and into another program or course at the school: 0. b) Completed or graduated from the Dental Assisting program: 11. Completed or graduated from the Orthodontic Assisting program: 26. c) Withdrew from school: 3. d) Are still enrolled in the Dental Assisting program: 0. Are still enrolled in the Orthodontic Assisting program: 0.
- 6. The number of students enrolled in the Dental Assisting Program who were: a) Placed in their field of study: 6. b) Placed in a related field: 5. c) Placed out of the field: 0 . d) Not available for placement due to personal reasons: 0. e) Not employed: 0. The number of students enrolled in the Orthodontic Assisting Program who were: a) Placed in their field of study: 12. b) Placed in a related field: 7. c) Placed out of the field: 1. d) Not available for placement due to personal reasons: 6. e) Not employed: 0.
- 7. The number of students who took a State licensing examination or professional certification examination, if any, during the reporting period: 0
- 8. The number of students who took and passed a State licensing examination or professional certification examination, if any, during the reporting period: 0
- 9. The number of graduates who obtained employment in the field who did not use the school's placement assistance during the reporting period: 18.
- 10. The average starting salary for all school graduates employed during the reporting period: a) Dental Assisting graduates: \$16.50/hr. b) Orthodontic Assisting graduates: \$16.50/hr.

**STUDENT SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_**

**PROGRAM COORDINATOR SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_**

**ILLINOIS HEALTH CAREERS DBA ILLINOIS DENTAL CAREERS WAS APPROVED TO OPERATE BY THE DIVISION OF PRIVATE BUSINESS AND VOCATIONAL SCHOOLS OF THE ILLINOIS BOARD OF HIGHER EDUCATION WITH NO ACCREDITATION FROM THE U.S. DEPARTMENT OF EDUCATION**



**DENTAL ASSISTING / ORTHODONTIC ASSISTING PROGRAM**

**PHOTO / VIDEO RELEASE FORM**

Permission to Use Photographs and Video

Subject: Materials to promote Illinois Dental Careers

I \_\_\_\_\_ grant permission to Illinois Dental Careers to their representatives and employees the right to take photographs, a video of me, and my property in connection with the above - identified subject. I authorize Illinois Dental Careers there assigns and transferees to copyright, use and publish the same in print and or electronically. I agree that Illinois Dental Careers can use such photographs/videos of me with or without my name and for any lawful purpose, including for example such purposes as publicity, advertising, and Web content while I am a student/intern and after the completion of my internship hours in Illinois Dental Careers and sister chain Orthodontic Experts, Ltd., I have read and I understand this document and agree that this release is binding on me, my heirs, assigns and personal representatives.

**STUDENT SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_

**STUDENT PRINTED NAME** \_\_\_\_\_





**DENTAL ASSISTING / ORTHODONTIC ASSISTING PROGRAM**

**CONSENT FORM FOR HUMAN SUBJECT**

As a student enrolled in the dental assisting programs, I am aware and have been informed of the need to practice patient care skills specific to dental assisting on fellow students during supervised laboratory class sessions. As a human subject used for practice and demonstration for educational purposes, I understand that my responsibilities are the following:

- To inform the class instructor prior to the lab session for that day if I am experiencing any oral pain or discomfort that could be detrimental to my participation in the lab class. A determination by the instructor will be made regarding student participation in the lab for that day.
- To immediately inform my lab partner and or instructor if I am experiencing any undue discomfort caused by the application of the procedure being practiced.
- To request that the supervising instructor assist in correcting my lab partner, and assist her or him in the correct application of the procedure. As a student practicing or demonstrating patient care skills on a human subject.
- My responsibilities are to comply with the instructor or human subject when asked to immediately stop the administration of a procedure. Students must be cognizant of both verbal and physical signs from the human subject, or from the instructor.
- To request assistance from the supervising instructor if needed. This includes asking for clarification about any portion of the procedure prior to its implementation.
- To respect the dignity of the human subject by ascertaining if the subject is comfortable both prior to and during the procedure, and by following the guidelines for appropriate dental care.

I have read and do understand the above guidelines. I agree to serve as a human subject for the practice and demonstration of patient care skills specific to practice as a dental assistant in the supervised laboratory. I release Illinois Dental Careers and my instructor from any and all liability and/or physical responses resulting from my service as a human subject.

**STUDENT SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_

**PROGRAM COORDINATOR SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_



**DENTAL ASSISTING / ORTHODONTIC ASSISTING PROGRAM**

**VOLUNTARY ASSUMPTION OF RISK & RELEASE OF LIABILITY**

THIS IS A RELEASE OF LEGAL RIGHTS. READ CAREFULLY BEFORE SIGNING. Illinois Dental Careers is a Career Training Program. References to Illinois Dental Careers include its officers, Board of Trustees, employees, and its designated agents.

As a student in Illinois Dental Careers Training Program, I, \_\_\_\_\_ freely choose to participate in the \_\_\_\_\_ Dental / Orthodontic Assisting Program \_\_\_\_\_ which I am enrolled.

**I agree as follows:**

**Initials:**

\_\_\_ **RISKS:** I understand that the clinical education environment for the Program in which I am enrolled through Illinois Dental Careers contains exposures to risks inherent in activities required for participation in the Program. These risks include, but are not limited to bodily injury, communicable and infectious diseases, and property damage.

\_\_\_ **HEALTH AND SAFETY:** I have been advised to consult with a healthcare provider regarding my personal medical needs. I have obtained the required immunizations. I recognize that Illinois Dental Careers is not obligated to attend to any of my medical or medication needs, and I assume all risks and responsibilities. In case of a medical emergency occurring during my participation in this Program, I authorize the representative of Illinois Dental Careers to secure whatever treatment is necessary. I agree to pay all expenses related to any treatment and release Illinois Dental Careers from any liability for any actions.

\_\_\_ **ASSUMPTION OF RISK AND RELEASE OF LIABILITY:** Knowing the risks described above, and involuntary consideration of being allowed to participate in the Program, I hereby knowingly assume all risks inherent in this activity and connected activities. I agree to release, indemnify, and defend Illinois Dental Careers and its officers, Board of Trustees, employees, its designated agents and independent contractors from all claims of any kind which I, the student, may have for any losses, damages or injuries arising out of or in connection with my participation in this Program.

**SIGNATURE:** I indicate that by my signature below, I have read the terms and conditions of participation in this Program and agreed to abide by them. I have carefully read this Voluntary Assumption of Risk and Release liability and acknowledge that I understand it. The laws of the State of Illinois shall govern this Voluntary Assumption of Risk and Release of Liability.

**STUDENT SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_

**PROGRAM COORDINATOR SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_



**DENTAL ASSISTING / ORTHODONTIC ASSISTING PROGRAM**

**HEPATITIS B DECLINATION FORM**

If you have previously received the HEP B vaccination, please provide proper documentation to Illinois Dental Careers. If you chose to opt-out of the vaccination, please sign the below statement, acknowledging you are declining:

Illinois Dental Careers will not pay for or reimburse for students to receive the HEP B shot.

**Declination Statement**

I understand that due to my occupational exposure to blood or other potentially infectious materials, I may be at risk of acquiring Hepatitis B virus. I have been given the opportunity to vaccinate with the Hepatitis B vaccine, at no charge to me. However, I decline Hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis B. If, in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with hepatitis B vaccine, I can receive the vaccination series at no charge to me.

**STUDENT SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_

**STUDENT PRINTED NAME** \_\_\_\_\_