CHOPTANK community health
see how healthy you can be!

Dental Preceptorship Program Application

Choptank Community Health System, Inc
Administration Office
301 Randolph St.
Denton MD 21629
Telephone: 410-479-2650

Instructions and Important Information

- The applicant must complete all forms and attach required copies of credentials.
- Forms must be hand-signed and dated. Electronic methods for adding a signature will not be accepted.
- Once completed, forms can be submitted electronically by email to: tosborn@choptankhealth.org . Applicant must assure all scanned copies are legible.
- A non-refundable application fee of $250.00 is required and due prior to the processing of the application. If the application is accepted, this fee will be applied to the total cost of the program.
- Methods of payment: Currently Choptank can accept money orders or cashier checks.
- Cashier's Checks or Money Orders must be made out to: Choptank Community Health System, Inc
- Application fee must be mailed to:
  Tammy Osborn
  Choptank Community Health System Inc.
  301 Randolph St., Denton MD 21629

Questions regarding this program or application process may be directed to:

Program questions	**Tumouh Al-Allaq, DDS, Program Director**	**410-228-9381 ext 5738**	**TAlAllaq@choptankhealth.org**
Application process	**Tammy Osborn, Credentials Specialist**	**410-479-8346**	**tosborn@choptankhealth.org**

The applicant may begin the program only when the background checks and primary source verifications have been completed and the applicant is deemed to be cleared.

Completing the Application Packet

Part 1: Dental Preceptorship Program Application (two pages). Complete both pages with all applicable information.

Part 2: International Consent/Authorization (one page). Read/complete information/print name/sign/date this page.

Part 3: Applicant Disclosure (one page). Read and return with application.

Part 4: Acknowledgement and Authorization (one page). Read/sign/date.

Part 5: User Code of Ethics (two pages). Read page one and two then one page two, print your name/sign/date.

Part 6: Confidentiality Agreement (one page). Read, print your name/sign/date.

Part 7: Required Vaccine Records for non-employed clinical staff at Choptank Community Health (2 pages). Read page one and then complete page two. Attach copies of your immunization records and ppd screenings.

Part 8: Health and Safety Training Acknowledgement (one page). Read, print your name/sign/date.

Part 9: Choptank Community Health System, Inc. Quality and Safety Handbook (pages 13 through 48). Read pages 13 – 48. The form you complete for Part 8 is the attestation that you have read this information.

Documentation to Submit with the Application Packet

Please attach copies of the documents listed below as applicable:

TWO FORMS OF IDENTIFCATION IS REQUIRED – acceptable examples listed below

- ○ **Passport**
- ○ **Driver's License OR valid State Identification Card**
- ○ **Visa**
- ○ **Green Card**
- ○ **Social Security Card**

REQUIRED DOCUMENTS TO SUBMIT WITH APPLICATION

- ○ **Two letters of recommendation**
- ○ **CPR card**
- ○ **CV/Resume**
- ○ **Dental School Diploma or graduate certificate**
- ○ **Dental School Transcripts**
- ○ **Dentist license (past and present)**
- ○ **Immunization/vaccine records**

Dental Preceptorship Program Application

Last Name: _____ First Name: _____ Middle Name: _____

Date of Birth: _____ Country of Origin: _____

Email: _____ Phone: _____

Dental School Attended (attach copy of diploma): _____ Graduation Date: _____

US Citizen YES or NO: _____

Social Security Number YES or NO _____ (if yes, attach copy of Social Security card)

Green Card YES or NO: _____ (if yes, attach copy of green card)

Visa YES or NO: _____ If yes, what visa type _____ (attach a copy of visa)

Immigration Status: _____ Other Status: _____

Additional Immigration Status Information: _____

Current Address (address/City/State/Country):

Address: _____

City: _____

State: _____

Country: _____

Previous Addresses (for past seven years): Use additional page if needed.

_____

_____

_____

_____

Preceptorship Desired (please check one):

- **Advance Education in General Dentistry, AEGD ____**
- **Community Dentistry Program ____**
- **Both ____**

Preceptorship Duration (please select one):

3 months, tuition: $6,000 ____ 6 months, tuition: $10,000 ____ 12 months, tuition: $17,000 ____

Locations	Address	City/State/Zip	Phone Number	Fax Number
Main Office Location				
Cambridge Dental Center	503 A Muir St	Cambridge, MD 21613-1848	410-228-9381	410-228-9384
Other Choptank Locations				
Goldsboro Dental Center	316 Railroad Ave, PO Box 122	Goldsboro, MD 21636-1126	410-482-2224	410-482-2511
Federalsburg Dental Center	215 Bloomingdale Ave	Federalsburg, MD 21632-1012	410-754-7583	410-754-7719
Bay Hundred Dental Center	933 S. Talbot St, Unit 4	St. Michaels, MD 21663	410-745-0200	410-745-0492
Denton Dental Center	609 Daffin Lane	Denton, MD 21629	410-479-2650	410-479-1626

By signing this application form, I confirm that all information listed by me is accurate. I certify that I have completed the education required to be eligible for this program, that I am physically and mentally capable to participate in this program, and that I do not have a physical or mental health condition (including alcohol or drug dependence). I understand that information disclosed by me will be verified by Choptank Community Health System Inc. and in the event an adverse finding is made or if I am at any time found to be in violation of the Choptank Community Health System 's Standards of Behavior, I will be removed from the preceptorship program without refund of the program fees paid by me.

Signature: _____ Date: _____

Tumouh Al-Allaq, BDS, DDS, FGD

Preceptorship Program Director Email: TAlAllaq@choptankhealth.org

Phone: 410-228-9381 ext 1738

Fax: (410) 479-1714`

Submit application and all documentation to:

Tammy Osborn, Credentialing Specialist
Choptank Community Health System Inc
301 Randolph St, Denton MD 21629
410-479-8346 Phone, 410-479-1714 Fax, tosborn@choptankhealth.org