Third Year Dental Hygiene Program

(Dental Hygiene Year 3 – Fall 2023)

The following list of questions may help you prepare for this fall:

1. Will there be a clinic orientation?

More information regarding clinic will be forthcoming.

2. What are my clinical medical requirements?

Please refer to the Placement Tab on the Dental Hygiene webpage for all information related to clinic.
https://www.stclaircollege.ca/programs/dental-hygiene

3. When will clinic begin and what are my clinic times?

More information regarding clinic will be communicated via Blackboard.

4. Will I need an 'enhanced' police clearance this year?

Yes. Please refer to the Placement Tab on the Dental Hygiene webpage for all information related to the police clearance (vulnerable sector).
https://www.stclaircollege.ca/programs/dental-hygiene

5. What textbooks will we be using for year 3?

Please contact the campus bookstore for textbooks required for year 3 of the dental hygiene program.

6. How do I select a General Education Elective?

All information regarding General Education Electives can be found here:
General Education (Elective) Requirements | St. Clair College (stclaircollege.ca)

DENTAL HYGIENE PROGRAM
ONE STEP T.B. TEST REQUIREMENT FORM FOR ENTRANCE INTO YEAR 3 CLINIC

I, ________________________________ Birthdate: ___________________________
(Student Signature)

Health Card # _________________________, Authorize Dr./N.P. ___________________
(Please Print)

TO RELEASE THE FOLLOWING INFORMATION TO ST. CLAIR COLLEGE.

NOTE TO PHYSICIAN/N.P.: It is recommended by the National Advisory Committee on immunization and the ONTARIO HOSPITALS ACT, REGULATIONS 518/88, that students in Health Care Programs meet the following health requirements in order to participate in the clinical component of the program.

If status is **unknown**: **a two-step** test is required.

Current T.B. skin test (+ve _________) (-ve __________) Date: ________________

IF POSITIVE INDURATION IS >10 mm__________ >15mm_____ >25 mm _____

CHEST X-RAY: YES _______ NO _______

ANY INDICATION OF ACTIVE DISEASE: YES _______ NO _______

PROPHYLAXIS GIVEN: YES ___________ NO _______

Physician/Nurse Practitioner Signature Section

Physician/Nurse Practitioner Signature _______________________ Date: ___________

Physician/Nurse Practitioner Stamp **(required)**

Comments of Physician/Nurse Practitioner: