Dental Experience Form

Please type or print

Applicant Name:

Semester and year that you will like to considered for selection: _____ (Semester) _____ (year)

Dental Hygiene Applicant:

Please have the dentist for whom you work/observe fill out the information below.

1. In what capacity did the applicant participate in your practice?
   - Chairside dental assistant
   - Hygiene assistant
   - Observation/Shadowing

2. How many total working hours was the applicant participating at your office?

3. Has the applicant received a certificate or degree in Dental Assisting from a CODA accredited institution? If so, then name the institution.

Signature of Referring Dentist ___________________________ Date ___________________________