PCC Dental Assisting Program

Dental Assisting Experience Verification Form

Applicant Name: ____ **Student ID:** ____________

(Applicant, please fill out above)

To be completed by the **Dentist or Clinic Coordinator** and returned to the applicant:

Name of Dental Office or Clinic	
Address	
Dentist / Coordinator Name	
Phone Number	
Email	
Indicate which option best represents the applicants experience (Check all that apply)	☐ Completed a screening appointment at the PCC Dental Clinic (approximately 4 hours) ☐ Shadowed a Dental Assisting Student at the PCC Dental Clinic (maximum of 8 hours) ☐ Shadowed a Dental Assistant at a Private Practice or Public Health Dental Clinic (minimum of 4 hours)
Date(s) of Experience	
Time(s) of Experience	
Total Hours Completed	

Dentist / Coordinator Signature _____________________________________ Date ___/___/____

This form must be completed and uploaded to the application by the July 1st deadline.