

Dental Assisting Work/Observation Experience Form

The person who supervises the observation/experience must sign the statement of observation/work experience form. When completing this form, indicate the types of dental-related experience. **PLEASE DOCUMENT THE TOTAL NUMBER OF HOURS/MONTHS OF OBSERVATION/WORK EXPERIENCE** (a minimum of $\underline{4}$ <u>hours</u> observation).

Applicant Name			
Please check all	applicable types of experience that	t pertain to the	applicant.
Observ	ved Dental Assisting Procedure(s)	Obse	erved Reception-Secretary Duties
Observ	ved Dental Hygiene Procedure(s)	Obs	erved Patient Education
Other	Duties Observed—please specify: _		
Please specify the completing the	ne amount of time devoted to dent following:	al assisting relat	ed work and/or observation by
Total Number o	f Hours Observed:		
Date(s) of super	vision:		
From:	20	То:	20
Please write any	additional comments on a below	or on a separate	piece of paper.
Please write any	<i>i</i> additional comments on a below	or on a separate	piece of paper.
Please write any	<i>i</i> additional comments on a below	or on a separate	piece of paper.
Please write any	<i>i</i> additional comments on a below	or on a separate	piece of paper.
Please write any	<i>i</i> additional comments on a below	or on a separate	piece of paper.
Please write any	y additional comments on a below	or on a separate	piece of paper.
Please write any	y additional comments on a below	or on a separate	piece of paper.