

CERTIFICATION OF DENTAL WORK EXPERIENCE

PRINT THIS FORM: Submit this form with your application and prior to the application deadline of February 28, 2018. If you do not have Dental Work/Volunteer Experience, the submittal of this form is not required.

If applicable, this form **MUST** be signed by the verifying dentist. This form may also be photocopied if more than one is needed.

I, _____ am applying for admittance to the Dental Hygiene Program at Taft College. I authorize release of the requested information on this form.

Signature of Applicant: _____ Date: _____

Dear Dental Professional:

Please complete this form for the person name above. This information is for use of the Taft College Dental Hygiene Program only. Thank you for your time.

This person was employed (circle one): FULL TIME or PART TIME or VOLUNTEERED with:

_____ DDS/DMD

from _____ through _____
(day, month, year) (day, month, year)

Total FULL TIME months worked and hours per week _____
(months) (hours)

Total PART TIME months worked and hours per week _____
(months) (hours)

Total VOLUNTEERED months /hours per week _____
(months) (hours)

He/She held the position(s) of _____ while employed here and had the following responsibilities:

I certify that the above statements are true to the best of my knowledge and verification of employee records are held in this office.

Signature of Dentist submitting the above information _____ Date _____

Printed Name of Dentist submitting above information _____

FORM can be sent via Fax to Taft College: 661-763-7758