CERTIFICATION OF DENTAL WORK EXPERIENCE

After receiving necessary signatures, upload and submit this form with your application, prior to the application deadline.

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

Signature of Applicant:_____Date:_____

Dear Dental Professional:

Please complete this form for the person named 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)

The Applicant held the position(s) of _____*while employed/volunteering 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 Dental Professional Date

_____
Printed Name of Dental Professional