TAFTCOLLEGE

CERTIFICATION OF DENTAL RELATED WORK EXPERIENCE

After receiving the necessary signatures, upload and submit this form with your application, prior to the application deadline. If you do not have dental related experience, you do not need to submit this form.

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

Date: _____

Dental Professional:

Please complete this form for the above applicant. The information is for use by the Taft College Dental Hygiene Program only. We appreciate your assistance, and thank you for your time.

This applicant is/was with DDS/DMD as a: ☐ Full-time employee ☐ Part-time employee ☐ Volunteer

Start Date: _____ End Date: _____

Total Work Hours: *(Complete all that apply)*

Full-Time: ____ Years ____ Months ____ Hours/Week

Part-Time: ____ Years ____ Months ____ Hours/Week

Volunteer: ____ Years ____ Months ____ Hours/Week

Position(s) held: _____

Responsibilities: _____

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

Printed name of Dental Professional:_____ Date: _____

Signature of Dental Professional:_____