

DENTAL EXPERIENCE OBSERVATION FORM

Name (Please Print)

PeopleSoft ID #

Telephone Number

Dentist's Name

Dentist's Office Phone Number

Dentist's Office Address

_____: **Number of Hours of Actual Dental Experience Observation**

(Dental Assisting Applicants require minimum of 12 hours)

Student Reaction to Experience: (completed by student)

Student's Signature

Date

Dentist/Assistant/Reaction to Experience: (completed by DMD/DDS, CDA/DA)

Dentist/Assistant/ Signature

Date

Date of Observation	Hours Completed
Total # of Hours:	

