DENTAL HYGIENE OBSERVATION/WORK EXPERIENCE FORM

The person who supervises the observation/experience must sign the statement of observation/work experience form. When completing this statement, indicate the types of dental-related experience. Question #4 should be itemized as to hours, days, weeks, etc. PLEASE ESTIMATE THE TOTAL NUMBER OF HOURS OF OBSERVATION/WORK EXPERIENCE. This document will be given consideration as a factor in the applicant's admission to the program.

1. Applicant Name_____ SS# _____

2. _____ Salaried Employee _____ Unsalaried Employee

3. Please check all applicable types of experience that pertain to the applicant.

_____ Observed dental procedure _____ Performed reception-secretary duties

_____ Assisted chairside _____ Provided patient education

_____ Performed expanded duties; specify _____

_____ Performed laboratory procedures

_____ Other; specify _____

4. Please specify the amount of time devoted to dental hygiene-related work and/or observation by completing the following:

Date under supervision:
_____, 20 ____ to _____, 20 ____

Hours per Day	_____	Months per Year	_____
Days per Week	_____	Years	_____
Weeks per Month	_____	**Total number of hours of observation/work experience**	_____

5. Please write any additional comments on a separate piece of paper.

_____ _____
Signature of supervising dental hygienist Date

_____ _____
Signature of applicant Date

This form must be completed and returned by February 15, 2002 to:

LCC Office of Admissions
200 Oswald Building, Cooper Drive
Lexington, KY 40506-0235

LEXINGTON COMMUNITY COLLEGE

NUCLEAR MEDICINE TECHNOLOGY OBSERVATION FORM

THIS IS TO CERTIFY THAT _____

SS# _____

HAS COMPLETED _____ HOURS OF OBSERVATION AT

_____ ON _____
(HOSPITAL) (DATE/DATES)

_____
CHIEF TECHNOLOGIST OR SUPERVISOR

INSTRUCTIONS

The student should:

1. Contact the Nuclear Medicine Department of the hospital in which you wish to perform your observation.
2. Set up a time with the Chief Technologist/Supervisor for your observation.
3. Complete the top portion of this form.
4. Have the Chief Technologist/Supervisor sign the form.

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Lexington, KY 40506-0235

LEXINGTON COMMUNITY COLLEGE

RADIOGRAPHY OBSERVATION/WORK EXPERIENCE FORM

Please inform the clinical instructor or supervising technologist if there is any chance that you could be pregnant.

1. Applicant name _____ SS# _____

2. Areas applicant may observe: (Please check all applicable categories).

. _____ Basic routine radiography _____ Fluoroscopy

. _____ Reception area _____ Film storage area

. _____ Emergency room

3. Amount of time devoted: _____

Date(s) under supervision: _____

Radiography Observation/Work Experience waived by: _____

4. Any additional comments you wish to make about the applicant:_____

_____

_____

_____

_____ _____

Signature of person supervising observation/work experience Signature of applicant to the program

_____ _____

Date Date

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Lexington, KY 40506-0235

LEXINGTON COMMUNITY COLLEGE

RESPIRATORY CARE OBSERVATION/WORK EXPERIENCE FORM

Applicants are encouraged to complete the observation/work experience requirement with our clinical faculty. However, the observation may be completed in any respiratory care department. To arrange an observation experience with program faculty, please call the program coordinator at (859) 257-4872, ext. 4106 or a program faculty member at (859) 257-4872, ext. 4107.

To ensure the candidate has an adequate exposure to the field of respiratory care, it is recommended that an observation experience last a minimum of four hours and include at least five of the procedures listed below.

1. Applicant name _____ SS# _____

2. Salaried Employee _____ Unsalaried Employee _____ Observation _____

3. Type of experience that pertains to the applicant (please check all applicable categories):

_____ Mechanical Ventilation _____ Delivery of Aerosolized Medications

_____ Bronchial Hygiene Therapy _____ Oxygen Administration

_____ Arterial Blood Gases _____ Pulmonary Function Testing

4. Date(s) of observation: _____

5. Approximate number of hours spent observing: _____

_____ _____

Signature of person supervising observation/work Signature of applicant

_____ _____

Date Date

This form must be completed and returned by February 15, 2002 to:

LCC Office of Admissions
200 Oswald Building, Cooper Drive
Lexington, Kentucky 40506-0235.