## **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.

	Applicant Name:	SS#:
	Salaried Employee:	Unsalaried Employee:
	Please check all applicable types of experience that pertain to the applicant.	
	Observed Dental Procedure Performed Reception-Secretary	
	Assisted Chairside	Provided Patient Education
•	Please specify the amount of time devoted to dental hygiene-related work and/or observation by completing the following:	
	Date under supervision:	
	From: 20	Го:20
	Hours Per Day	Months Per Year
	Days Per Week	Years
	Weeks Per Month	Total Number Of Hours
	Are you a graduate of an accredited dental assisting program?  Yes  No	
	If you answered yes to #5, have you successfully passed the DANB? Yes No	
	If so, please submit documentation of this ce	ertificate to the Office of Admissions.
	Please write any additional comments on a separate piece of paper.	
		<del></del>
	Signature of Supervising Dental Hygieni	ist Date
	C'andrea (Caracia Davida	
	Signature of Supervising Dentist	Date

This form must be completed and returned by February 15 of the year in which you wish to enroll.

Please send this form to:

Bluegrass Community And Technical College Office Of Admissions 200 Oswald Building, 470 Cooper Drive Lexington, KY 40506-0235