

## 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: \_\_\_\_\_ Unsalared 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 Other Duties—specify \_\_\_\_\_

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

Date under supervision:

From: \_\_\_\_\_ 20\_\_\_\_ To: \_\_\_\_\_ 20\_\_\_\_

Hours Per Day \_\_\_\_\_ Months Per Year \_\_\_\_\_

Days Per Week \_\_\_\_\_ Years \_\_\_\_\_

Weeks Per Month \_\_\_\_\_ Total Number Of Hours \_\_\_\_\_

5. Are you a graduate of an accredited dental assisting program? Yes No

6. If you answered yes to #5, have you successfully passed the DANB? Yes No  
If so, please provide documentation of the DANB certificate.

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

\_\_\_\_\_  
Signature of Supervising Dental Hygienist

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Supervising Dentist

\_\_\_\_\_  
Date

Please submit to:

**Bluegrass Community and Technical College, Office of Admissions - 200 Oswald Building,  
470 Cooper Drive, Lexington, KY 40506-0235**