

DENTAL ASSISTING EXPERIENCE OBSERVATION FORM

Name (Please Print)

People Soft Number

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 a minimum of 12 hours)

Student Reaction to Experience: (completed by student)

Student's Signature

Date

Dentist/Assistant/Hygienist Reaction to Experience: (completed by DMD/DDS, DA or RDH)

Dentist/Assistant/Hygienist's Signature

Date

Date of observation: _____ Hours: _____

Date of observation: _____ Hours: _____

Date of observation: _____ Hours: _____

Date of observation: _____ Hours: _____