

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. **Minimum is 4 hours.**

1. Applicant Name: _____ PS#: _____

2. Salaried Employee : _____ Unsalariated 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 submit documentation of this certificate to the Office of Admissions.

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

Signature of Supervising Dental Hygienist

Date

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