

**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 experie nce 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	_____	<b>Total number of hours</b>	_____
		<b>of observation/work experience</b>	_____

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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**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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**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 \_\_\_\_\_ Unsalariated 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

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200 Oswald Building, Cooper Drive  
Lexington, Kentucky 40506-0235.**