DENTAL HYGIENE PROGRAM **Revised July 2016**

DENTAL EXPERIENCE VERIFICATION FORM

Due Date: March 1

Applicant First and Last Name:

Applicant TCC CWID#: T

Have you submitted multiple verification forms? Yes No
If yes, what number is this form? _____ of _____ *(2 of 3; 1 of 2; etc.)*
Please submit no more than 3 verification forms per application year.
Only one verification form is used during the selection process. The selection committee will use the verification form that favors the applicant best.

Applicant Instructions: Points are awarded based on your level of dental experience. In order to receive points, each applicant is required to provide proof of experience or hours of observation. Points range from 0-5 and are only awarded in **one** category. Please make additional copies of this form, if needed. As our application requirements/processes change from time-to-time, please review this form for updates each year you apply. It is not necessary to submit a new verification(s) each year you apply unless the new verification form would affect your point total.

Dear Doctor, Hygienist, or Dental Assisting Program Director, please complete the following information to verify the experience of the applicant listed for his/her admission file. Please ensure that you sign on the appropriate line and mail this form to the address given below for the applicant to receive credit.

Dental Experience or Observation	
Put an X in the box below that **best** corresponds to the amount of experience or observation the applicant received in your office/program **within the past 5 years:**	Experience or Observation
	➢ Chairside dental assisting for at least one year
	➢ Dental Assisting Program with Internship
	➢ Chairside less than one year
	➢ Observations with RDH 40+ hours
	➢ None (or less than 40 hours)
Dates of experience/observation - **Start date:**	**End date:**
Signature of Employing DDS:	
Signature of Hygienist Observed:	
Signature of Dental Assisting Program Director:	
Printed Name of Signature Above:	
Dental Office/Program Name:	
Address:	
Phone:	
Date:	

Please mail this form directly to:
Tulsa Community College
Allied Health Services, MP 458
Attention: Daniele Dennison
909 S. Boston Ave.
Tulsa, OK 74119-2095

This form is not valid if returned by the applicant. *It must be mailed by the office/school completing the form. Please mail back in an office/school envelope. We reserve the right to call and verify this information. Thank you for your assistance.*