Portland Community College

PCC Dental Assisting Program

PCC Dental Clinic Experience Verification Form

Applicant Name: _____

Applicant Student ID Number: _____

(Applicant, please fill out the above information)

The information below must be completed by a PCC coordinator or instructor at the PCC Dental Clinic in order for the applicant to have their experience considered.

Coordinator/Instructor Name: _____

Coordinator/Instructor Title: _____

Coordinator/Instructor Email: _____

Experience:

- ☐ Shadowed for 3 hours
- ☐ Completed a patient assessment

Date(s) of experience: _____

Total hours shadowing (if applicable): _____

Type of assessment (if applicable): _____

I verify that the above-identified applicant has either completed assessment and/or shadowed at the PCC Dental Clinic. PCC reserves the right to contact anyone listed on this form to verify that the information is true and correct. **Incomplete forms will not be accepted.**

Coordinator / Instructor Signature: _____ **Date:** ___/___/_____

This form must be uploaded to the PCC Dental Assisting application.