THOMAS NELSON COMMUNITY COLLEGE
DENTAL HYGIENE PROGRAM
DOCUMENTATION OF CHAIRSIDE DENTAL ASSISTING WORK EXPERIENCE

Applicants must use a **separate** form for documenting all dental assisting work experience for **each** dental office. Please obtain an official office stamp on this form.

Applicant's Name: _____

Dentist's Name: _____

Office Address: _____
Street Address

_____
City State Zip Code

Office Telephone: _____
Area Code Telephone Number

Office E-mail Address: _____

Applicant's Position Title: _____

Dates of Service: _____ to _____
Month/Year Month/Year

Please indicate if the Applicant was:

Full-Time ≥ 32 hours/week: _____ or Part-Time: _____
If Part-Time: Hours per Week _____

I certify that the above information is correct and accurate for this applicant who is applying to Thomas Nelson Community College's Dental Hygiene Program.

_____ _____
Dentist's Signature Date

Official Office Stamp:

NOTE: There are to be **NO** substitutions such as letters when accounting for work experience as a dental assistant working chairside in a dental practice. This is the **ONLY** form that will be reviewed and scored as part of the admissions process.