CERRITOS COLLEGE HEALTH OCCUPATIONS DIVISION DENTAL HYGIENE PROGRAM

VERIFICATION OF DENTAL EMPLOYMENT

This form is to be completed by the Dentist and returned to the applicant for submission with their application which must be submitted to the Dental Hygiene Program no later than April 1.

NAME OF APPLIC	ANT			
Please Pl	Print: First Name following. The above in	ndividual is/has be	Last Name en an employee in m	ny office.
Dates: <u>from</u>		to		
Hours per week:				
Job Description:				
GENERAL INFOR	RMATION			
	EXCELLENT	ABOVE AVERAGE	AVERAGE	BELOW AVERAGE
Appearance				
Speech				
Personality				
Integrity				
Maturity				
Motivation				
Comments:				
NAME OF DENTIS	ST/EMPLOYER			
ADDRESS				
PHONE				
DENTAL LICENSE NUMBER		DATE		
SIGNATURE OF D	ENTIST			