

**Halifax Community College
Dental Hygiene Program
Dental Office Experience Documentation Form**

Applicant: _____

Social Security Number: _____

Type of Dental Assisting Classification:

____ DA I
____ DA II
____ CDA Date of Certification: _____

Years of Experience:

____ 3 + Years Full-Time Work
____ 1-3 Years Full-Time Work
____ 1 + Years Part-Time Work (8-25 hours per week)

Documentation by Employer

Please print the information below:

Dentist's Name: _____

Address: _____

Phone: _____

I certify that the above information concerning the dental experience of this applicant is correct.

Signature of Dentist: _____

Date: _____