PCC Dental Hygiene Program

PCC Dental Clinic Shadowing Verification Form

Part I: To Be Completed by The Applicant
Applicant Name:
Student ID Number:

By signing below, I certify that I have completed 3.5 hours of shadowing at the PCC Dental Clinic by the end of PCC's Winter term. I certify that I understand that providing false or incomplete information on this form will result in nullification of points.

Applicant Signature: _____ **Date:** ___/___/_____

Part II: To be completed by the Dental Clinic Coordinator or Dental Hygiene Lead Instructor
Coordinator / Instructor Name:
Coordinator / Instructor Title:
Coordinator / Instructor Email:
Date(s) of shadowing:
Total hours shadowing:

I verify that the above-identified applicant has 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 page must be uploaded to the documents section of your DHCAS application.