PCC Dental Hygiene Program

Dental Hygienist Shadowing Documentation Form

Applicant Name: _____ **Student ID:** _____
(Applicant, please fill out above)

The information below must be completed by the dental hygienist who the applicant shadows in order to receive 2 points in the Phase I evaluation:

Name of Dental Office	
Address	
Dental Hygienist Name	
Phone Number	
Email	
Shadow Date(s)	
Shadow Time(s)	
Total Shadowing Hours Completed	

I verify the above information is complete and true. PCC reserves the right to contact anyone listed on this form to verify the information listed is true and correct. **Forms will not be accepted if incomplete.**

Hygienist's Signature _____ **Date** ____/____/_____

This completed form must be uploaded to the documents section of the DHCAS application.