



PCC Dental Hygiene Program  
**Dental Experience Documentation Form - Part I**

<b>Applicant Name:</b>	<b>Applicant Student ID Number:</b> <b>G0</b>
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**Applicants may earn up to 5 points for Dental Experience in ONE of the categories listed below. Please check off the box that reflects your Dental experience hours:**

<input type="checkbox"/>	800 hours employment = <b>6 points</b>
<input type="checkbox"/>	DANB Certified Dental Assistant (CDA) or enrolled in a CDA program = <b>7 points</b>

- Healthcare experience hours must be complete by the **end of the PCC winter term** prior to the application deadline. Experience points will not be awarded if forms are incomplete or if supporting documentation of dental assisting certification or paid work experience hours is missing.
- Failure to upload supporting documentation will affect consideration for experience points.
- **All required documentation must be uploaded to your DHCAS online application by 8:59pm PST (11:59pm EST) on the application deadline.**
- Documentation submitted after the deadline will not be considered.
- By signing below, I certify that I have uploaded proof of dental experience for consideration by the admission evaluation committee.
- By signing below, I certify that I understand that providing false information on this form will result in nullification of application and/or dismissal from the program.
- I understand that I must submit both pages of this form for my experience to be considered
- Forms will not be accepted for point consideration without a valid signature.

**Applicant Signature:** \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Both pages of this completed form must be uploaded to the documents section of the DHCAS application.**



PCC Dental Hygiene Program  
**Dental Experience Documentation Form - Part II**

<b>To Be Completed by the Supervisor/ DANB CDA Instructor/ Dentist</b>			
<b>Supervisor/ DANB CDA Instructor/ Dentist Contact Information:</b>			
Applicant Name & Title:			
Dental Office, Clinic, or CDA Program Name & Address:			
Supervisor, CDA Instructor, or Dentist Name:			
Supervisor/ CDA Instructor, or Dentist Title:			
Primary Contact Phone:			
Email Address:			
<b>Dates of Employment/Service:</b>	Begin Date:	End Date:	
<b>Hours completed by the end of Winter Term:</b>	Total Hours:		
Is this position a paid employee? (Please check one)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Is a certification required for this position?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
If <b>YES</b> , please specify the certification type:			
Please provide a brief description of the position/service performed OR attach a detailed position description which the applicant will need to upload to their DHCAS application:			

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 on this form. **Forms will not be accepted without a valid signature.**

**Supervisor/CDA Instructor/Dentist Signature:** \_\_\_\_\_ **Date:** \_\_/\_\_/\_\_

**Both pages of this completed form must be uploaded to the documents section of the DHCAS Application.**