



PCC Dental Hygiene Program  
Dental Hygienist Shadowing Documentation Form

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

**To be completed by the dental hygienist who the applicant shadows and returned to the applicant 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 without a valid signature.**

**Hygienist's Signature** \_\_\_\_\_ **Date** \_\_\_\_/\_\_\_\_/\_\_\_\_

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