QUALIFICATION FORM

THE REQUIREMENTS FOR THIS COURSE IN EXPANDED FUNCTIONS INCLUDE:

1. CHAIRSIDE DENTAL ASSISTING FOR MORE THAN 6 MONTHS
2. ABILITY TO SPEAK AND UNDERSTAND ENGLISH BECAUSE THIS PROGRAM IS PRESENTED ENTIRELY IN ENGLISH

I, DR._____ CERTIFIES THAT
employer

_____ HAS BEEN
assistant

EMPLOYED BY ME AS A CHAIRSIDE DENTAL ASSISTANT FOR MORE THAN 6 MONTHS AND SPEAKS AND UNDERSTANDS ENGLISH.

_____ FL LIC. #_____
(dentist's signature)

DATE_____

OFFICE ADDRESS: _____

_____

_____

THIS QUALIFICATION FORM MUST BE COMPLETED AND TURNED IN AT THE FIRST CLASS MEETING OR FAX TO 954-262-3990