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:

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