CDHL APPLICANT SHADOWING FORM

Applicants to the BS/MS Dual Degree CDHL Program may use this form to document their shadowing hours. This form may be submitted with other supplemental materials.

_________________________________________           __________________________________

APPLICANT NAME:          LAST
FIRST

_____________________________________________________________________________________

STREET ADDRESS _____________________________________________________________

CITY __________________________ STATE ___________ ZIP CODE __________ COUNTRY

SHADOWING VERIFICATION
To the dental hygienist. Thank you for your willingness to assist this applicant in his/her
familiarization with the dental hygiene profession.

The applicant named above completed _________ hours of observation in this office on
___________________________ (date).

If other than general practice, please specify specialty:________________________________________

List the types of procedures observed:

Comments (optional):

Dental Hygienist’s Signature

_________________________________________ _______________________________________

Office Address _________________________________________________________________

Office Telephone (__________) _____________________________