UNIVERSITY OF MARYLAND – SCHOOL OF DENTISTRY

DENTAL HYGIENE PROGRAM

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 (_____) _____