

**dəxʷx̌ayəbus-Dental Therapy Program**

**Verification of Work/Volunteer Experience**

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| **Instructions to Applicant:** This form is to be completed for each site/clinic by the employer/supervisor or human resources representative of each. UPLOAD this completed form as part of dəxʷx̌ayəbus(pronounced: dahf-hi-ya-buus) -Dental Therapy Program Application. \*Faxed copies will not be accepted.  **Instructions to Representative Completing Work/Volunteer Experience Form:** Please read verification statement, complete and sign all fields, and return to Applicant for their submission to dəxʷx̌ayəbus-Dental Therapy Program at Skagit Valley College.  *Questions: Contact dentaltherapy@skagit.edu.* |

Applicant with current or recent work/volunteer experience in the dental field involving patient, hygienist, dental reception or dentist contact will suffice admissions requirement of dəxʷx̌ayəbus-Dental Therapy Program if work/volunteer experience is within the last 10 years and is documented on this form.

Minimum of **200** dental experience hours is required.

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| Applicant’s Name: |  | Dates of Experience: |  |
| Place of Experience: |  | Total Hours  (Do not enter hours per week) |  |
|  |  |  Paid  Volunteer | |

**Brief** description of job title or responsibilities/duties.  Do not attach a formal job description or copies of employee evaluations.

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| **Applicant’s Attestation Statement** | | |
| *I understand the completed 200/+ hrs. of dental experience is an admissions requirement for dəxʷx̌ayəbus-Dental Therapy Program at Skagit Valley College. I do hereby attest the above listed hour are true, accurate, and complete. I understand that any falsification, omission, or concealment of fact may subject me to automatic withdraw of my application to dəxʷx̌ayəbus-Dental Therapy Program at Skagit Valley College.* | | |
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| Applicant Name (printed) |  | Date |
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|  |  |  |
| Applicant Signature | Email Address **(Required)** | Telephone Number **(Required)** |

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| **Site/Clinic Verification Statement** | | |
| *I do hereby attest that this information is true, accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact will negatively affect the applicant’s admissions status to dəxʷx̌ayəbus-Dental Therapy Program at Skagit Valley College.* | | |
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| Representative Name (printed) | Title (printed) | Date |
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|  |  |  |
| Signature | Email Address **(Required)** | Telephone Number **(Required)** |

**SVC Dental Therapy Department Use Only:**

**Receipt Date: (initials)**

**Verification Date: (initials)**

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