Employer Work Verification Statement – Coronal Polishing Course
FAX TO: (859) 257-0486 – UK College of Dentistry/Continuing Education

(Please TYPE or PRINT)

Name of Employer/Dentist ____________________________________________________________

Address of Employer/Dentist __________________________________________________________________________

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Phone ______________________________________

Name of Participant/Assistant ______________________________________________________________

I hereby verify that the above named participant has been in my employment for:

☐ 12 Months within the past three years or has 12 months combined experience at 1 or more dental offices. Please attach a letter verifying this if the experience includes two or more dental offices.

(If an assistant has worked for more than one dentist during the required time period, the participant may attach a letter from all employers/dentists during the one year time period OR the current employer may choose to verify all employment even if the participant has worked for other dentists in prior years.)

OR

☐ I hereby verify that the above named participant has successfully completed a dental assisting program. Please fax supporting documentation with this form to (859)257-0486.

During the tenure of employment, I further verify that I have personally trained or can verify that the participant has been trained in the following areas. (If the assistant does not perform all of these functions in the office, she/he must still possess a basic understanding of them in order to increase their likelihood of success in this course.)

☐ Preliminary examination of patients (Intraoral and Extraoral)
☐ Charting oral conditions/completing treatment documentation
☐ Taking and recording patient’s vital signs
☐ Four-handed dentistry techniques
☐ Preparation and understanding of armamentarium for intraoral procedures
☐ Performing and assisting with intraoral procedures
☐ Managing patients physical and psychological needs
☐ Preventing/managing medical emergencies
☐ Maintaining aseptic conditions/preventing cross-contamination
☐ Performing sterilization and disinfection procedures

Signature of Licensed Dentist______________________________________________ Date____________

Dentist License Number __________________________________________________________________

Rev. 10/16/19