SPOKANE COMMUNITY COLLEGE

Dental Assisting Program Form

OBSERVATION/VOLUNTEER VERIFICATION

TO BE COMPLETED BY APPLICANT

I would like to request your assistance in providing verification of my observation hours/volunteer service with your organization. I have applied for acceptance to the Spokane Community College Dental Assisting Program. This form is necessary to complete my application to the Dental Assisting Program at Spokane Community College. My signature below authorizes my former or current volunteer organization to provide the information requested below.

Student's Name (typed): _____
Last *First* *Middle*

Student's Signature: _____ Date: _____

TO BE COMPLETED BY VOLUNTEER SUPERVISOR
(This section may be handwritten by the supervisor)

Student's Name: _____
(Last) *(First)* *(Middle)*

Observation/Volunteer Supervisor's Name: _____

Facility / Business name: _____

Address: _____
Street or PO box *City* *State* *ZIP Code*

Phone: _____
###.###.####

Position or title applicant held while observing/volunteering for your organization:

_____

Primary duties or responsibilities: _____

_____

Start and end dates of observation/volunteer service within the last two years:

_____

Number of observation/volunteer hours within the last two years _____

_____

I certify under penalty of perjury under the laws of the State of Washington that the foregoing is true and accurate.

Supervisor's Name (Please Print) _____

Supervisor's Signature: _____ Date: _____