The Dental Education Institute, LLC
810 West De Soto Street
Clermont, FL 34711
352.551.6531

Training Verification Form

I, __________________________ (doctor's name) confirm that ________________________ (student's name) has been training directly under my supervision for at least six months in chair side dental assisting. I am a licensed dentist in the State of Florida. He/she has had experience learning all aspects of dentistry within my practice. I agree that he/she is ready and capable of completing an Expanded Functions Certification Course.

____
Doctor's Signature/License Number

____
____
____
Doctor's Address/Phone Number

____
Student's Signature

____
Signature of School Official

____
Date