The Dental Education Institute, LLC
810 West DeSoto 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 three months in dental radiology. I am a licensed dentist in the State of Florida. He/she has had experience learning all aspects of dental radiology within my practice. I agree that he/she is ready and capable of completing a Dental Radiology Certification Course.

_____

Doctor's Signature/License Number

_____

_____

_____

Doctor's Address/Phone Number

_____

Student's Signature

_____

Signature of School Official

_____

Date