STATE OF MAINE
BOARD OF DENTAL PRACTICE
143 STATE HOUSE STATION
AUGUSTA, ME 04333-0143

Independent Practice Dental Hygiene Clinical Practice Verification Form

Use a separate form for each person verifying experience and for each employment setting.
If more space is needed, attach an additional sheet. Please print clearly.

Applicant Data (To be completed in full by Applicant)		
Name of Licensee:	License Number:	
Mailing Address:		
City:	State:	Zip Code:
Work Telephone:	Original Licensure Date:	
Place of Employment During Clinical Practice:		

Education and Clinical Supervision Hours Qualifications (To be completed in full by Applicant)	
2,000 clinical hours	[ ] RDH clinical supervision hours [ ] RDH w/Public Health clinical supervision hours

I ATTEST THAT ALL OF THE INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE.

Signature of Applicant: _____ Date: _____

Independent Practice Dental Hygiene
Clinical Practice Verification Form

Supervising Dentist Information (To be completed in full by Supervising Dentist)		
Name of Supervising Dentist:	License Number:	
Mailing Address:		
City:	State:	Zip Code:
Work Telephone:	Home Telephone:	

Clinical Practice Information of Applicant* (To be completed in full by Supervising Dentist)	
Total Number of Hours Applicant Worked Per Month	
Total Number of Hours Per Month Supervised Clinical Practice was Provided	
Total Number of Hours Applicant Worked	

Dates the Applicant was Under your Supervision: From_____ (month/day/year) To _____ (month/day/year)

(Note: The supervision must be 2,000 clinical practice hours.)

1. Do you recommend that this applicant be granted the authority to practice dental hygiene independently? [ ] YES [ ] NO If not, please describe why:

_____

_____

_____

_____

I ATTEST THAT ALL OF THE INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE. I ALSO AGREE TO RETURN THIS FORM TO THE LICENSEE FOR MAILING TO THE BOARD OF DENTAL PRACTICE.

Signature of Supervising Dentist: _____ Date: _____