



Verification of 7-Year Dent Shadowing Experiences
with a General Practitioner (you may shadow 1 dentist or more)

Name of Student: _____

Dentist No. 1

Name of Dentist (Print): _____

Location: _____

No. of Hours Shadowing: ____

Signature of Dentist: _____ Date: _____

Dentist No. 2

Name of Dentist (Print): _____

Location: _____

No. of Hours Shadowing: ____

Signature of Dentist: _____ Date: _____

Dentist No. 3

Name of Dentist (Print): _____

Location: _____

No. of Hours Shadowing: ____

Signature of Dentist: _____ Date: _____

Dentist No. 4

Name of Dentist (Print): _____

Location: _____

No. of Hours Shadowing: ____

Signature of Dentist: _____ Date: _____

To the Student: Once you have completed the 25 hours of shadowing experience, please scan/email this form to Dr. Snyder at snyderke@udmercy.edu or bring to her office E126.