UNIVERSITY OF FLORIDA COLLEGE OF DENTISTRY
CONTINUING DENTAL EDUCATION

CERTIFICATION OF PARTICIPANTS FOR RADIOLOGY COURSE

*****PLEASE NOTE THAT THIS FORM MUST BE *SIGNED AND MAILED/FAXED BACK TO THE CONTINUING DENTAL EDUCATION AT LEAST ONE WEEK PRIOR TO THE START* OF THE RADIOLOGY COURSE.**

By my signature below, I certify that I possess a minimum of three (3) months of continuous on-the-job training through assisting in the **positioning and exposing of dental radiographic film** under the direct supervision of a licensed dentist, or have graduated from a Board-approved dental assisting or hygiene program **and am at least 18 years of age**. I understand that if one or more of the instructors of the Radiology course determines during any part of the course that I do not have the appropriate dental experience or background as stipulated above, **that I can be dismissed from the course without receiving a refund of any registration fees.**

PLEASE SIGN BELOW AND RETURN TO:

UF Continuing Dental Education
P.O. Box 100417
Gainesville, FL 32610-0417
OR
FAX to (352) 294-5594

Participant Signature _____Date_____

Printed Name _____

Dentist Signature _____ Date:_____

Printed Name _____