UNIVERSITY OF FLORIDA COLLEGE OF DENTISTRY CONTINUING DENTAL EDUCATION

CERTIFICATION OF PARTICIPANTS FOR EXPANDED FUNCTIONS AS PERMITTED BY FLORIDA LAW

*****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 Expanded Functions as Permitted by Florida Law course.**

TO BE COMPLETED AND SIGNED BY PARTICIPANT

By my signature below, I certify that I am at least 18 years of age and possess a minimum of three months of chair-side experience as a dental assistant or dental hygienist in general dentistry, or an equivalent combination of education and experience*. I understand that if one or more of the instructors of the Expanded Functions as Permitted by Florida Law 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 excused from the course without receiving a refund of any registration fees.

Describe the length and type of on-the-job chair-side dental assisting experience in general dentist office(s) and/ or education you have received: (Receptionist and Lab Tech's are not qualified for this course, unless they have the above mentioned chair-side dental assisting experience). Use additional paper if necessary.

_____

_____

_____

Please check the procedures below that you have had experience with:

- o Taking Impressions
- o Topical application of fluoride
- o Placing & removing rubber dams
- o Placing and removing perio dressings
- o Polishing clinical crowns for stain removal
- o Polishing amalgam restorations
- o Fabricating provisional crowns
- o Temp cementation of provisional crowns
- o Placing & removing matrices
- o Placing intra-coronal provisional restorations
- o Placing bases & liners
- o Suture removal
- o Application of pit & fissure sealants
- o Preliminary charting
- o Packing and removing retraction cord

Signature of Participant_____Date_____

Printed Name_____

TO BE COMPLETED AND SIGNED BY DENTIST

By my signature below, I certify that the information provided by the dental auxiliary above is accurate and that they possess the basic dental assistant knowledge and skills necessary to perform well in this course.

Dentist Signature_____Date_____

Printed Name _____