Dentist Agreement of Participation & Employment Verification Form

Dental Assisting (CFDAC) Pathway II (ADAEP)

Students applying to the Dental Assisting-Pathway II (ADAEP) program at WCC must be **employed as a chairside dental assistant** for a **minimum of 24 hours per week** in a dental office. Both the student and employing dentist must verify participation and employment. To do so, the employing dentist must complete this form. The student must complete the Student Agreement of Participation Form.

Important: The information provided on both forms **must match**, including the semester, year, dental office/practice name, and participating/employing dentist.

Submit to: Health & 2nd Tier Admissions Office at healthadmissions@wccnet.edu or Student Welcome Center (2nd Floor, Student Center).

TO BE COMPLETED BY DENTIST:

Student Name: _____ **Student ID:** _____

Please select the semester and indicate the year of participation:
This agreement is valid only for the semester and year indicated below.

- ☐ **Fall Semester** (August-December) - **Year:** _____
- ☐ **Winter Semester** (January-May) - **Year:** _____

Dentist Acknowledgements
By signing below, you confirm that you have read and understand the following:

1. I verify that the student named above is **currently employed a minimum of 24 hours per week as a chairside dental assistant** in my dental office.
2. I agree to **assist this student in meeting program requirements** and to evaluate the student according to the evaluation guidelines provided by the Dental Assisting program at Washtenaw Community College.
3. I agree to participate in an **on-site evaluation** of the student by a WCC faculty member.
4. I agree to **actively participate in the student's education**, observe and evaluate their performance, and provide my signature on required validation form(s).
5. I understand that the student's acceptance and continuation in the program is conditional upon **maintaining at least 24 hours per week of chairside dental assisting employment** in my office under my supervision.
6. I agree to **notify Tina Sprague, Dental Assisting Program Director** (734-973-3337 or ksprague@wccnet.edu) **immediately** if the student leaves my employment during their enrollment in the program.

***Employing/Participating Dentist Signature:** _____ **Date:** _____

Employing/Participating Dentist Name (printed): _____

Dentist License Number: _____ **Expiration Date:** _____

Dentist Email: _____

Dental Office/Practice Name: _____

Address: _____ **City:** _____ **State:**_____ **Zip:** _____

Phone Number: _____ **Fax Number:** _____

***A handwritten signature is required from the Employing/Participating Dentist.** Electronic signatures are not valid.