College of Engineering & Science
Dean's Office

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. Roberts-Kirchhoff at robkires@udmercy.edu or bring to her office Engineering Rm 245.

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