

APPENDIX B

VALIDATION OF WORK/VOLUNTEER EXPERIENCES

To: SIAST Dental Hygiene Program

Re (applicant's name): _____

This is to verify that _____ was
employed/volunteered from (start date) _____ until (end date)
_____ in the position of _____.

While employed she/he worked an average of _____ hours per week.

Signature of Validator

Date

Contact Information

Name of Validator: _____

Job Title: _____

Employer/Organization/Agency name: _____

Telephone: _____

Fax: _____

E-Mail: _____