SCHOOL OF MEDICINE
DENTAL HYGIENE

Shadowing Hours Form

Please complete one form for each Registered Dental Hygienist (RDH) shadowed.

Applicant Information (applicant should complete)

Applicant Name: _____ **Application Deadline:** _____

Registered Dental Hygienist (RDH) Information (RDH should complete)

RDH Name: _____

RDH License #: _____ **Email Address:** _____

Dental Office Name: _____

Office Manager Name: _____

Office Phone Number: _____

SHADOWING HOURS

Date of Shadowing	Start Time	End Time	Total Hours

Notes:

RDH Signature: _____ **Date:** _____

Office Manager Signature: _____ **Date:** _____

This form MUST be uploaded in the document section under "Observation Hours" in ADEA DH CAS for the specified applicant.