University of Arkansas for Medical Sciences
Department of Dental Hygiene
4301 W. Markham Street, Slot 609
Little Rock, AR 72205

DENTAL OFFICE OBSERVATION FORM

Dental Hygiene Applicant: ____

Reference Name: ____
Address: ____
City/State/Zip: ____
Telephone: ____

Capacity in which you have known the applicant (e.g.: dentist or dental hygienist, etc.) *We ask that the applicant does not observe in the dental office of a family member.*
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Professional Reference: How many hours did this applicant observe/work? _______________

Dates: From ______________________ to ________________________

Please rate the applicant's performance in terms of the following qualities (check all that apply).

	Superior	Good	Average	Fair	Poor
Sense of responsibility					
Punctuality					
Dependability					
Personal appearance					
Ability to work without supervision					
Interpersonal relations with fellow workers					
Interpersonal relations with patients/clients					

Briefly, describe your impression of the seriousness of purpose and professional attitude of the applicant in their choice of career as a dental hygienist. Please use the back of this form if needed.

____ ______________________
Signature of Reference Date

Mail to: Dean's Office, College of Health Related Professions, 4301 West Markham Street, Slot 619, Little Rock, AR 72205