Secretary of State
Office of Professional Regulation

DENTAL EXAMINERS
Affidavit of Experience/Supervision for Dental Therapist

To be completed by the Dental Therapist:	
Dental Therapist's Name:	
State of Practice:	
Signature:	

To be completed by Supervising Dentist verifying the Dental Therapist's supervised practice:		
Practice Name:		
Practice Address:		
Supervisor Name:		
Supervisor License #:		
State of Practice:		
Based on your personal knowledge of the dental therapist:		
When did he or she begin practicing as a dental therapist under your supervision?	Date as MM/YY:	
Indicate the number of hours the applicant worked:	Hours:	
I hereby certify that the dental therapist has completed 1,000 hours of direct patient care using dental therapy procedures under my supervision, Statute § 614 (a) (1)		**YES NO**

Signature of Supervisor

I certify, under the pains and penalties of perjury, that all information I have provided in this application is true and accurate. I understand that furnishing false information may constitute unprofessional conduct and result in the denial of my application or further disciplinary action. The maximum penalty for perjury is fifteen years in prison and/or a $10,000 fine. (13 V.S.A. §2901)	
Signature of Supervisor	Date