Dental Hygiene Program Shadowing Hours Completion Form
Due by February 15th

Student Name ___________________________________________  Student ID# ______________________

Shadowing Agency Name ________________________________________________________________

Shadowing Agency Address _____________________________________________________________

Shadowing Agency Phone Number ______________________________________________________

Date(s) of shadowing/observation ______________________________________________________

Total # of hours completed __________ (minimum of 16 required)

Shadowing Supervisor* Signature _______________________________________________________  

Shadowing Supervisor Printed Name ____________________________________________________

Shadowing Supervisor Phone Number ____________________________________________________

Shadowing Supervisor Email ___________________________________________________________

Student Signature ________________________________________________________________

* Please note that WCC may contact the shadowing supervisor to verify hours. This form may be mailed, faxed, or emailed to the Admissions Office using the contact information on the header of this form. Only complete forms will be accepted.