

University of Mississippi Medical Center

School of Health Related Professions

Department of Dental Hygiene

Verification of Observation Form*

This is to certify that _____ observed _____

hours in this dental hygiene practice in partial fulfillment of admissions requirements for the Department of Dental Hygiene, School of Health Related Professions, University of Mississippi Medical Center.

Comments:

Name of Applicant _____ Social Security Number _____

Dental Hygienist _____ Title _____

Facility _____ Date _____

***Observation hours completed for the current application year. This form may be duplicated if necessary.**

Return completed form to: Office of Student Records and Registrar
The University of Mississippi Medical Center
2500 North State Street
Jackson, MS 39216-4505

Application ID: