

WORK EXPERIENCE VERIFICATION FORM

This section is to be completed by the applicant:

APPLICANT'S Last Name: _____ **First Name:** _____

Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____

Email: _____ **Phone number:** _____

SELECT ONE CATEGORY OF WORK EXPERIENCE. Circle the points that show your years of experience.

Points

Full-time Dental Related employment (min 2 years)

20

Full-time/Part-time Dental Related employment (min 1 year)

15

Full-time employment (min 2 years)

15

Full-time/Part-time employment (min 1 year)

10

Full-time/Part-time employment (min 3 months)

6

Volunteer/Community Service work (100 hours minimum)

3

This section is to be completed by the employer:

Business Name (Printed): _____

Address: _____ **City:** _____ **Zip:** _____ **State:** _____

Employer Phone: _____ **Email:** _____

Applicant's dates of employment: From (start date): _____ **Through (end date):** _____

Position title: _____

Employment status: _____ **Full-time** _____ **Part-time** _____ **Volunteer**

Applicant's Job Responsibilities: _____

Employer's Attestation: My signature verifies that this is an accurate record of the applicant's work experience.

Supervisor's NAME (PRINTED): _____

Signature: _____ **Date:** _____

FOR OFFICE USE ONLY: VERIFIED: ☐ YES ☐ NO

DATE: _____ **INITIALS:** _____ *Updated 9/22/26 GTO*