WORK EXPERIENCE VERIFICATION FORM

Please fill out the top section of the form and give it to your employer. Make sure they return it to you, then email it to dentalhygiene@shoreline.edu.

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. We do not combine years or months from different work experiences.	**Points**
Full-time Dental Related employment (min 2 years)	20
Full-time/Part-time Dental Related employment (min 1 year)	15
Full-time health care employment (min 2 years)	15
Full-time/Part-time health care employment (min 1 year)	10
Full-time NON health care work experience (min 1 year)	10
Part-time NON health care work experience (min 1 year)	8
Full-time/Part-time employment (less than 1 year)	6
Dental Related Volunteer/Community Service work (100 hours minimum)	6
General Volunteer/Community Service work (100 hours minimum)	5

This section 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 02/25/25 GTO*