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EMPLOYMENT VERIFICATION

(MUST BE COMPLETED BEFORE A NOTARY PUBLIC)

Name of Employing Dentist(s) or Agency:										_
Complete Mailing Address:										_
Telephone Number: Fax Number:										
Email Address										_
" ,(Print name & Title of the Employing Dentist				DE	DS / I	DMD /	agenc	y repre	esentative,	
(Print name & Title of the Employing Dentist	or Agency	Represe	ntative)							
certify that(Print Applicant/Employee Nam	e)	, was	emplo	yed by	me	in the	clinical	, ethica	al, and lega	Э
practice of a(Print Job Title)	from	Month	// Day	Year	_ to ₋	Month	_/	Year	•	
Dentist's/Agency Representative Signature				Da	ate			_		
State of										
County/City of										
Sworn and subscribed to, before me, this _	Day	_day of		Mon	th	,	Yea	 ar		
My commission expires onMonth	Day	Yea	 ar							
SEAL/STAMP		Signature of Notary Public								
		Print Name								