



## COLLEGE OF DENTAL TECHNOLOGISTS OF ONTARIO

### RECORD OF SUPERVISED DENTAL TECHNOLOGY EXPERIENCE

|                                         |                                               |                  |
|-----------------------------------------|-----------------------------------------------|------------------|
| <b>Candidate's (Applicant's) Name:</b>  | <b>Business Name and Address:</b>             | <b>Position:</b> |
| <b>Dates of Candidate's employment:</b> | <b>From:</b>                                  | <b>To:</b>       |
| <b>Supervisor's Name:</b>               | <b>Business Name and contact information:</b> | <b>Position:</b> |

|                                                                                                                  |
|------------------------------------------------------------------------------------------------------------------|
| <b>I supervised the candidate's ( applicant's) work and trained them in:</b>                                     |
| <input type="checkbox"/> Complete dentures for _____ hours <input type="checkbox"/> Orthodontics for _____ hours |
| <input type="checkbox"/> Crowns, inlays, onlays, posts, cores, bridges and dental ceramics for _____ hours       |
| <input type="checkbox"/> Partial dentures for _____ hours                                                        |

|                                                                                                                                                                                                                                                                                     |                                                              |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------|
| <b>Declaration of Supervising Health Professional</b>                                                                                                                                                                                                                               |                                                              |
| <i>The Undersigned acknowledges that the CDTO will be relying on this record as evidence of the above named applicant's supervised training and that the applicant has given permission to the College to verify information. This document is part of the application process.</i> |                                                              |
| <b>I hereby certify that all of the statements made by me in this document are true and to the best of my knowledge.</b>                                                                                                                                                            |                                                              |
| _____<br><b>Name of Supervising Health Professional</b><br>(Please Print)                                                                                                                                                                                                           | _____<br><b>Signature of Supervising Health Professional</b> |
| _____<br><b>Registration Number (with CDTO/ RCDSO)</b>                                                                                                                                                                                                                              | _____<br><b>Date</b>                                         |