



**District of Columbia
Health Professional Licensing Administration
Board of Dentistry**

DENTAL ASSISTANT GRANDFATHERING ATTESTATION

Name of Dental Assistant Applicant	Place of Employment (name of office)	Location of Office	Hire Date End Date
			____/____/____ MM DD YYYY ____/____/____ MM DD YYYY

Was the dental assistant working at this office in a competent manner prior to and including July 15, 2011? Yes No

If no, please provide the location of the office that will be verifying the applicant's work as a dental assistant.

Name of Dentist: _____ Location/Place of Employment: _____

Was this individual under your supervision prior to and including July 15, 2011? YES NO

By signing this attestation, I, _____, hereby attest that the information that I have provided on this Attestation Experience Form is true and complete to the best of my knowledge. I understand that making a false statement on this document, including all writings and attachments, may result in the Department of Health taking action against me that it deems appropriate.

Signature of Supervising Dentist: _____ Date: _____