EFDA EMPLOYMENT VERIFICATION FORM

Authorized Dental Employer should complete the following:

Name of Employer/Dentist: _____

Dentist's License Number: _____

Address: _____

Phone Number: _____

Email address: _____

Name of Employee: _____

Address: _____

Phone Number: _____

Email address: _____

Date of Hire: _____

I HEREBY ATTEST THAT THE ABOVE-NAMED EMPLOYEE HAS BEEN IN MY EMPLOYMENT FOR (check box):

☐ **At least 4,500 hours of clinical dental experience in preparation for the Expanded Functions Dental Auxiliary Program (EFDA)**

During the tenure of employment, I further attest to the fact that I have personally trained or can verify that the candidate has been trained in the following areas. If this dental assistant does not perform all these functions in the office, she/he must still possess a basic understanding of them in order to increase his/her likelihood of success in the workshops provided by NHTI. (Check all that apply)

☐ **Infection control & proper hand washing technique**

☐ **Aseptic technique and preventing cross-contamination**

☐ **Equipment disinfection and sterilization methods**

☐ **PPE (Personal Protective Equipment)**

☐ **Standards and guidelines of occupational safety for dental office personnel**

☐ **Assisting with intraoral procedures**

☐ **Four-handed dentistry techniques**

☐ **Importance of treatment documentation**

- [ ] **Patient management techniques**
- [ ] **Knowledge of proper plaque control techniques**
- [ ] **Use, handling & characteristics of dental materials**
- [ ] **Processes and procedures for the laboratory**
- [ ] **Radiation safety for patient and operator**
- [ ] **HIPPA and confidentiality**

Supporting Dentist (have supporting dentist sign below)

I am a NH-licensed dentist in good standing with the NH State Board of Dental Examiners.

I commit to providing this EFDA trainee in 120 hours of clinical training in performing intra-oral procedures (restorations) in my dental office once the trainee has successfully completed classroom and pre-clinical instruction.

I agree to participate in on-site meetings with the EFDA Program Coordinator to discuss trainee progress in the clinical setting.

Name: _____

Date: _____

Signature: _____

Please return by mail to: Business Training Center

NHTI, Concord's Community College

31 College Drive

Concord, NH 03301-7412

Or email to: nhtibtc@ccsnh.edu