



## VERIFICATION OF EMPLOYMENT

South Florida Dental Assisting School requires verification of employment prior to attending any classes.

STUDENT NAME \_\_\_\_\_

CURRENT EMPLOYER \_\_\_\_\_

EMPLOYER ADDRESS \_\_\_\_\_

EMPLOYER'S PHONE / E-MAIL \_\_\_\_\_

EMPLOYMENT DATES \_\_\_\_\_

STUDENT SIGNATURE \_\_\_\_\_

STUDENT EMAIL ADDRESS \_\_\_\_\_

I have read the information given above and verify the information to be correct. ***If any infomation is falsified a certificate will not be given.***

By signing this form I acknowledge that I have formally trained the student in all Expanded Functions and Radiology procedures.

DATE \_\_\_\_\_

DOCTOR'S SIGNATURE \_\_\_\_\_

DOCTOR'S LICENSE # \_\_\_\_\_

OFFICE E-MAIL \_\_\_\_\_

CLASS DATE \_\_\_\_\_

**South Florida Dental Assisting School**  
3101 N Federal Hwy, Suite 501  
Oakland Park, FL 33306  
Phone: 954-445-1085  
Fax: 954-351-7927

**South Florida Dental Assisting School**  
2387 West 68th Street, Suite 302  
Hialeah, Florida 33016  
Phone: 305-469-8190  
Fax: 954-351-7927

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