SERVICE LEARNING CREDIT REQUEST

Name: _____ Graduation Year: _____

Phone: (Hm)_____ (Cell) _____ Box #: _____

Date(s) of Service: _____ No. of Hours_____

Organization Name: _____

Street Address: _____ City_____ State_____Zip _____

Event Leader: _____ Contact Number: _____

Non-Dental (Give a brief description of the activity)

_____

_____

_____

Dental Service (i.e., Health Fair Screenings, volunteering in a dental practice, etc.)
(Brief description of activity)_____

_____

_____

_____

Exam/Screen_____
Oral Surgery_____
Prophylaxi _____
Periodontic_____

Sealants_____
Fillings_____
Prosthodontic_____
Endodontic_____

Hygiene Education_____
Fluorides_____
Radiographs_____
Other_____

Counseling: Tobacco Treatment/Cessation,Nutrition & Oral Health Care: _____

Total Patients Treated: _____ **Total Procedures Performed:** _____

Student Signature: _____

Supervisor/Event Leader Signature_____ Phone Number _____