

DENTAL STUDENT PROGRAM REPORT*

Name of Program/Institution:
Type of Educational Program:
Location of Dental Facility:
Sponsoring/Affiliated Accredited Entity: (dental school, hospital etc), address
Supervising Dentist or Hygienist and the level of supervision:
Names of Students participating:
Typical length of program:
Pt populations served and approximate percentage of each in workload: (Medicaid, low income, private patients, etc)
Types of services offered and approximate percentage (eg: dentures 10%, restorative 20%)
Approximate total number of hours of clinical care provided per week;
Describe the arrangements for after hours/emergency care and follow-up care:
Other information you feel is important for our records:

* In addition to an initial report, please provide an annual report to the Board in June, or sooner if the program is terminated.