



# COMMISSION OHIO DENTAL ASSISTANT CERTIFICATION

**This form must be attached to exam application**

## Instructor Recommendation

I hereby recommend the following student(s) to take the Certified Ohio Dental Assistant exam.

Applicants Name: \_\_\_\_\_

**NOTE:** If more than one student, list all students below. Once notarized copy and attach a copy to **each** student's application.

**List Students or attach list**

Check one below

\_\_\_\_\_ Student(s) are currently enrolled in the second year of a two year Dental Assisting Program

Completion date: \_\_\_\_\_  
Month Year

\_\_\_\_\_ Student(s) has or will have completed at least 50% of a post-secondary Dental Assisting Program prior to the exam date.

Completion date: \_\_\_\_\_  
Month Year

The above named student has maintained above average grades and has demonstrated responsibility, ethical conduct and excellent dental assisting skills in all areas of the dental profession.

Student(s) are excellent representative for the dental profession.

Signed

Instructor: \_\_\_\_\_, CDA, CODA, RDH, EFDA  
(Circle all that apply)

School: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_, Ohio Zip \_\_\_\_\_

Notarized seal/signature