



Allied Health Department  
EFDA Program  
University of Cincinnati  
9555 Plainfield Road  
Blue Ash, OH 45236

## Supervising Dentist Commitment Form

I understand that my auxiliary \_\_\_\_\_ is applying to the UCBA EFDA Program and that if accepted, I will be expected to allow her / him to place restorations in office (amalgam, composite, bases, liners, and sealants) on patients under my Direct Supervision during the second semester of the Program in order to fulfill the Ohio State Dental Board required hours (80 hours) of clinical patient care.

I further understand that I will receive from my auxiliary (once enrolled) information to learn about the grading criteria, additional expectations, and be presented a document requiring my signature indicating my office be used as a remote site facility while my auxiliary is attending the EFDA Program.

(If applicant is a CDA) I attest that the applicant \_\_\_\_\_ has worked as a chair-side dental assistant a minimum of two out of the last five years.

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(Print name – Dentist)

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(Signature – Dentist) (Date)