

### DENTAL EXTERNSHIP WEEKLY EVALUATION FORM

<b>Name of Intern</b> (print first and last name)	<b>Period of this evaluation</b> (Date)

**DAILY ATTENDANCE** (Example: Monday 9:00 am – 5:00 pm)

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
<b>Total Hours this period</b>			<b>Hours earned to date</b>			

Note: This evaluation form must be submitted on Friday of each week to the Externship Coordinator at ACT. Fax this form weekly and the original must be mailed with 3 days of transmittal. Deviations from the above criteria will result in rejection of the evaluation period and the period must be repeated.

NOTE TO THE SUPERVISOR: Please review with student prior to submitting to ACT Externship Office.

**A TOTAL OF 220 HOURS OF UNCOMPENSATED INTERNSHIP PRACTICE IS REQUIRED FOR PROGRAM COMPLETION & GRADUATION.**

**RATINGS:**    **NA** = Not Observed    **EX** = Excellent    **G** = Good    **S** = Satisfactory    **U** = Unsatisfactory

**OVERALL PROFESSIONAL DEVELOPMENT**

Appearance		Patient Relations		Subject Knowledge/Theory	
Work Habits		Staff Relations			

**ADMINISTRATIVE ASSISTING SKILLS**

Collections		General Office Skills		Office Machines	
Telephone Skills		Appointment Scheduling		Mail Processing	
Filing		Reception		Computer Skills	
Insurance Processing					

**CLINICAL ASSISTING SKILLS**

Patient Seating & Preparation		Assisting Periodontal Surgery	
Diagnostic Skills		Assist Amalgam	
Develop & Mount X-rays		Take BW's, PA, FM X-rays	
Take Alginate & Bite Registration		Instrumentation & Set-up	
OSHA, Sterile Technique		Dental Materials Understanding	
Assist Composite		Assist C&B	
Fabricate Provisional		Cement Removal	
Assist Exodontia		Assist Pedodontics	
Charting		Record Management	
Emergency Medicine		CPR Understanding	

**OVERALL COMMENTS:**

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**Required Signatures:**

Supervisor: \_\_\_\_\_ Date: \_\_\_\_\_

Intern: \_\_\_\_\_ Date: \_\_\_\_\_