



# Washtenaw Community College

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## DENTIST/MENTOR AGREEMENT OF PARTICIPATION

Assistant's Name: \_\_\_\_\_

***I agree to be an active participant and mentor for the assistant entered above. I further agree to observe and evaluate this assistant's performance and submit my signature on the appropriate validation form(s.)***

Doctor's name printed: \_\_\_\_\_

Doctor's signature: \_\_\_\_\_

License Number: \_\_\_\_\_ Exp date: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Please fax this form to the WCC Dental Assistant Program at the following number: 734-677-5334
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