

## EFDA Program Applicant Form

If you have any questions, please reach out to [admissions@wctc.edu](mailto:admissions@wctc.edu).

Student name \_\_\_\_\_ Student ID \_\_\_\_\_

Phone \_\_\_\_\_ WCTC Email \_\_\_\_\_

Please initial the following:

\_\_\_\_\_ EFDA Program Applicant has a minimum of 2,000 hours of dental assistant experience,  
as verified by the supervising licensed dentist.

Dental Office name and phone number:

\_\_\_\_\_

Supervising Dentist's signature:

\_\_\_\_\_

*Handwritten signature*