Verification of Volunteer Participation in the Nova Scotia Weekly Fluoride Mouthrinse Program

(This form is to be completed by the Public Health dental hygienist supervising the Weekly Fluoride Mouthrinse Program.*)*

Date: _____

This verifies that _____ has attended
_____hours of
(*volunteer dental hygienist name)*

training/refresher for the Nova Scotia Weekly Fluoride Mouthrinse Program on _____.
(date)

The above named Dental Hygienist has volunteered for _____ hours with the Nova Scotia Weekly Fluoride Mouthrinse Program from September - December _____& _____hours from January - June _____.

Signed

Name: _____

Public Health Dental Hygienist

District _____

Address: _____

Phone: _____

Email: _____

*** Please note that this letter is only to confirm participation with the Nova Scotia Weekly Fluoride Mouthrinse Program. Please refer to the College of Dental Hygienists of Nova Scotia Continuing Competency Guidelines for further details regarding credits at www.cdhns.ca.**