**DENTAL CERTIFICATE**

\_\_\_\_\_\_\_\_semester, Academic Year: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

🞏 Teaching Personnel 🞏 Non-teaching Personnel 🞏 Student

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| **Date of Examination:** | | | |  | | | | | | | | | | | |
| **Name:** |  | | | | | | | | **Age:** | | |  | **Gender:** |  | |
| **Position/Year Level:** | | |  | | | | **Program/Department:** | | |  | | | | |
| **Emergency Contact Name:** | | | | |  |  | | | | | | | | | |
| **Relationship:** | |  | | | | | | **Tel/CP No.** | | |  | | | | |

To whom it may concern,

This is to certify that Mr./Ms.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ was seen and examined on \_\_\_\_\_\_\_\_\_\_\_ due to:

🞏 Mouth Examination 🞏 Gum Treatment 🞏 Oral Prophylaxis 🞏 Extraction

**Remarks:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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|  |  |  |
| *Signature Over Printed Name*  *School Nurse* |  | *Signature Over Printed Name*  *School Dentist*  *License Number: \_\_\_\_\_\_\_\_\_*  *PTR No: \_\_\_\_\_\_\_\_\_\_\_\_* |

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