**DENTAL CERTIFICATE**

\_\_${sem}\_\_semester, Academic Year: \_\_${ay}\_\_

${tp} Teaching Personnel ${ntp} Non-teaching Personnel ${stu} Student

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Date of Examination:** | | | | **${date}** | | | | | | | | | | | |
| **Name:** | **${pn}** | | | | | | | | **Age:** | | | **${age}** | **Gender:** | **${g}** | |
| **Position/Year Level:** | | |  | | | | **Program/Department:** | | | **${pro}${col}/${col}${dep}** | | | | |
| **Emergency Contact Name:** | | | | |  | **${emc}** | | | | | | | | | |
| **Relationship:** | | **${emr}** | | | | | | **Tel/CP No.** | | | **${mob} / ${tel}** | | | | |

To whom it may concern,

This is to certify that Mr./Ms.\_\_\_\_\_\_${pn}\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ was seen and examined on \_\_${date}\_\_ due to:

${me} Mouth Examination ${gt} Gum Treatment ${op} Oral Prophylaxis ${e} Extraction

**Remarks:**

\_\_\_${r}\_\_

|  |  |  |
| --- | --- | --- |
| **${n\_n}** |  | **${dn\_n}** |
| *Signature Over Printed Name*  *School Nurse* |  | *Signature Over Printed Name*  *School Dentist*  *License Number: \_${dn\_l}\_\_*  *PTR No: \_${dn\_no}\_\_* |

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