STATE OF MAINE
Board of Dental Practice
143 STATE HOUSE STTION
AUGUSTA, ME 04333-0143

DENTURIST TRAINEE SUPERVISION FORM

(Revised 09/2021)

Denturist Trainee Applicant Information		
Name of Denturist Trainee Applicant:		
Mailing Address:		
City:	State:	Zip Code:

Denturist/Dentist Supervisor Information		
Name of Supervisor:	License Number:	
Practice Name and Location:		
City:	State:	Zip Code:

Denturist/Dentist Supervisor - Registration Agreement

1) Duration(s) of the clinical supervision: _____
2) Anticipated denturist procedures to be completed under my supervision pursuant 32 M.R.S. § 18378 and denturist practice requirements outlined in Board Rule Chapter 12. The following procedures will be performed under the level of supervision as listed below – **please circle the level of supervision for each procedure listed**. (Use separate sheet if needed.)

A.	Direct Supervision General Supervision
B.	Direct Supervision General Supervision
C.	Direct Supervision General Supervision
D.	Direct Supervision General Supervision

By signing, I understand that the Maine Board of Dental Practice will rely upon this information to authorize the denturist trainee applicant to perform denturist procedures under my supervision in accordance with the Board's regulations. Performance of these services by the trainee will add to the trainee's knowledge and skill in denturism. I also agree to not commence supervision of this applicant until the application is approved by the Board.

SUPERVISOR'S SIGNATURE: _____ DATE: _____