GEORGIA STATE BOARD OF DENTISTRY
237 Coliseum Drive
Macon, GA
31217-3858

Supervising Dentist Monthly/Quarterly Report Form

Instructions to Supervisor: Please complete this form to assist the Board of Dentistry in monitoring the practice of this dentist. **ALL** reports should be mailed to the Board office by the 5th of the month following reporting period.

Reporting Period_____(month/quarter)

Supervisor's Name_____

Name of Licensee_____ License Number_____

Name of Practice_____

Street Address_____

City_____ State_____ Zip_____

Phone Number_____

Licensee's: Position_____

Schedule_____

Categories	Comments
Attendance	
Quality of Work	
Attitude	
Number of Hours Worked	Week 1: _____ OR Month 1: _____ Week 2: _____ Month 2: _____ Week 3: _____ Month 3: _____ Week 4:

Signature of Preparer_____

Printed Name of Preparer_____

Title of Preparer_____

Date_____

Additional Comments_____

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Name: _____

Signature: _____

Date: _____