

# Practitioner Five Year Work History\*

Please complete this form in its entirety.

---

Provider Name

Virginia Dental License Number

---

**Practice/Employer Name**

---

Employer Address

Date of employment, from \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_

---

**Practice/Employer Name**

---

Employer Address

Date of employment, from \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_

---

**Practice/Employer Name**

---

Employer Address

Date of employment, from \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_

---

**Practice/Employer Name**

---

Employer Address

Date of employment, from \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_

---

**Practice/Employer Name**

---

Employer Address

Date of employment, from \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_

*\*Curriculum vitae, résumé, or other documents stating work history are welcomed in lieu of this sheet. If you are a recent graduate, simply state as such, as we are required to have a five year history for all providers.*