

**IDHA SCHOLAR SOCIETY LOG OF CONTINUING
EDUCATION/COMMUNITY SERVICE HOURS**

This log must be completed, signed, and returned along with the Scholar Society application. I certify the following to be true and correct.

Name: _____ **License #** _____
Home Address: _____

E-mail _____ **Gender:** _____ **Ethnic origin:** _____

Dental Hygiene School of Graduation and Year: _____

Academic level:

Certificate/Associate _____ **Baccalaureate** _____ **Masters** _____ **Doctoral** _____
Degree Completion _____

of hours per week work and type of position: _____

of Dentists you presently work with per week: _____ **Salary range per hour:** _____

of years an ADHA/IDHA member. _____ **Date renewal** _____

DATA WILL BE USED FOR RESEARCH PURPOSES ONLY.

Log CE hours only. DO NOT SUBMIT COPIES OF DOCUMENTATION

In order for application to be considered, you must submit sufficient information to demonstrate completion of the appropriate number of continuing education credit hours (50 hours and 10 hours of community service).

DOCUMENTATION OF CONTINUING EDUCATION REQUIREMENT

NAME OF SPONSOR: _____

COURSE TITLE/
SUBJECT MATTER: _____

LOCATION: _____ DATE _____ HOURS OBTAINED: _____

NAME OF SPONSOR: _____

COURSE TITLE/
SUBJECT MATTER: _____

LOCATION: _____ DATE _____ HOURS OBTAINED: _____

NAME OF SPONSOR: _____

COURSE TITLE/
SUBJECT MATTER: _____

LOCATION: _____ DATE _____ HOURS OBTAINED: _____

NAME OF SPONSOR: _____

COURSE TITLE/
SUBJECT MATTER: _____

LOCATION: _____ DATE _____ HOURS OBTAINED: _____

NAME OF SPONSOR: _____

COURSE TITLE/
SUBJECT MATTER: _____

LOCATION: _____ DATE _____ HOURS OBTAINED: _____

NAME OF SPONSOR: _____

COURSE TITLE/
SUBJECT MATTER: _____

LOCATION: _____ DATE _____ HOURS OBTAINED: _____

NAME OF SPONSOR: _____

COURSE TITLE/
SUBJECT MATTER: _____

LOCATION: _____ DATE _____ HOURS OBTAINED: _____

NAME OF SPONSOR: _____

COURSE TITLE/
SUBJECT MATTER: _____

LOCATION: _____ DATE _____ HOURS OBTAINED: _____

NAME OF SPONSOR: _____

COURSE TITLE/
SUBJECT MATTER: _____

LOCATION: _____ DATE _____ HOURS OBTAINED: _____

NAME OF SPONSOR: _____

COURSE TITLE/
SUBJECT MATTER: _____

LOCATION: _____ DATE _____ HOURS OBTAINED: _____

NAME OF SPONSOR: _____

COURSE TITLE/
SUBJECT MATTER: _____

LOCATION: _____ DATE _____ HOURS OBTAINED: _____

NAME OF SPONSOR: _____

COURSE TITLE/
SUBJECT MATTER: _____

LOCATION: _____ DATE _____ HOURS OBTAINED: _____

NAME OF SPONSOR: _____

COURSE TITLE/
SUBJECT MATTER: _____

LOCATION: _____ DATE _____ HOURS OBTAINED: _____

NAME OF SPONSOR: _____

COURSE TITLE/
SUBJECT MATTER: _____

LOCATION: _____ DATE _____ HOURS OBTAINED: _____

COMMUNITY SERVICE

EVENT SPONSOR: _____ DATE _____

DESCRIPTION OF SERVICE: _____

LOCATION: _____ HOURS VOLUNTEERED: _____

EVENT SPONSOR: _____ DATE _____

DESCRIPTION OF SERVICE: _____

LOCATION: _____ HOURS VOLUNTEERED: _____

EVENT SPONSOR: _____ DATE _____

DESCRIPTION OF

SERVICE: _____
LOCATION: _____ HOURS VOLUNTEERED: _____

EVENT
SPONSOR: _____ DATE _____

DESCRIPTION OF
SERVICE: _____

LOCATION: _____ HOURS VOLUNTEERED: _____

EVENT
SPONSOR: _____ DATE _____

DESCRIPTION OF
SERVICE: _____

TOTAL HOURS OF CONTINUING EDUCATION: _____

TOTAL HOURS OF COMMUNITY SERVICE: _____

I verify that the information I have provided on this form is true and accurate.

Signature: _____ Date: _____

Please make copies of all information submitted. The Scholar Society will not be responsible for retrieving information concerning documentation of continuing education/community service hours.

SCHOLAR SOCIETY USE ONLY

Date received: _____ Date reviewed by Scholar Society Committee: _____

- Approved Date: _____
- Requested additional documentation Date: _____
- Denied Date: _____

Reason for denial: _____

Send application and log of continuing education/community service along with payment to:

Regina L. Pfister
ATTN: Scholar Society
144 Fairway Vista
Murphysboro, IL 62966