

**Concordia Learning Center at St. Joseph's School for the Blind**

761 Summit Ave., Jersey City, NJ 07307

(201) 876-5432/ Fax (201) 876-5430

**Dental Examination**

Name of Student \_\_\_\_\_

Date \_\_\_\_\_

Dear Doctor,

Your patient attends St. Joseph's School for the Blind. Please complete the following:

This certifies that I have examined the above named student and:

\_\_\_ All necessary dental work is completed.

\_\_\_ Treatment is in progress.

Further recommendations include:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
**Dentist's Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Dentist's Printed Name**

**Dentist's Address:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Phone Number:** \_\_\_\_\_