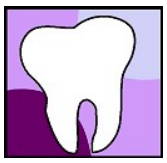
CHDP Dental Training: Fluoride Varnish Evaluation Form



Date: _____ Office/Clinic: _____ County: _____

I am a: ☐ Physician ☐ Nurse Practitioner ☐ Nurse ☐ Physician Assistant ☐ MA

Other Staff (specify) _____ Dental Professional (specify) _____

1. After this presentation are you more confident in your ability to apply fluoride varnish?

   ☐YES ☐NO

   If no, why not? _____

   _____

2. Will you provide fluoride varnish applications for children under 6 who are at risk for dental caries?

   ☐YES ☐NO

   If no, why not? _____

   _____

3. Do you need clarification on any of the following fluoride varnish topics? (check all that apply)

   ☐ Risk Assessment ☐ How to apply ☐ Who can apply

   ☐ Frequency of application ☐ Post application parent instructions ☐ Reimbursement

   Comments: _____

   _____

4. If you would like more dental resources or training please give your contact information:

   Name _____Phone _____

   Email _____

Thank you!

Please return evaluation to trainer