

DENTAL HYGIENE SCHOOL

NAME: _____

ADDRESS: _____

CITY/ST/ZIP: _____

DEAN/DIRECTOR

NAME: _____

PHONE: _____

EMAIL: _____

LOCAL ANESTHESIA WRITTEN & CLINICAL EXAM ELIGIBILITY. This is to certify that the following students have successfully completed both the **didactic** and **clinical** coursework requirements in the administration of local anesthetics; and have demonstrated clinical competency sufficient to attempt both the **WREB Local Anesthesia Written and Clinical Exams**.

AFFIX SCHOOL SEAL
HERE
(IF MAILED)

SUBMIT FORM: Dean/Director ONLY from authorized email. All fields required except school seal. Form not accepted if sent from candidate or unauthorized faculty.

Send to: hygieneinfo@wreb.org

SIGNATURE OF DEAN/DIRECTOR (REQUIRED)

Student Name		Date of Local Anesthesia Course Completion	WREB LOCAL ANESTHESIA WRITTEN & CLINICAL EXAMS
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