

DENTAL HYGIENE SCHOOL

NAME: _____

ADDRESS: _____

CITY/ST/ZIP: _____

DEAN/DIRECTOR

NAME: _____

PHONE: _____

EMAIL: _____

LOCAL ANESTHESIA WRITTEN-ONLY EXAM ELIGIBILITY. This is to certify that the following students have successfully completed the **didactic portion** of a course in the administration of local anesthetics; and have demonstrated competency sufficient to attempt the **WREB Local Anesthesia Written-ONLY Exam**.

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	Completion Date of DIDACTIC Portion of Local Anesthesia Course	WREB LOCAL ANESTHESIA WRITTEN-ONLY EXAM
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