DENTAL HYGIENE SCHOOL	DEAN/DIRECTOR
NAME:_____	NAME:_____
ADDRESS:_____	PHONE:_____
CITY/ST/ZIP:_____	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@cdcawreb.org

_____
SIGNATURE OF DEAN/DIRECTOR *(REQUIRED)*

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