| **DENTAL HYGIENE SCHOOL** | **DEAN/DIRECTOR** |
|---|---|
| NAME:____________________________________ | NAME:____________________________________ |
| ADDRESS:__________________________________ | PHONE:___________________________________ |
| CITY/ST/ZIP:________________________________ | 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@cdcawreb.org

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***SIGNATURE OF DEAN/DIRECTOR*** *(REQUIRED)*

| | Student Name | Completion Date of DIDACTIC Portion of Local Anesthesia Course | WREB LOCAL ANESHTESIA WRITTEN-ONLY EXAM |
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