

DENTAL HYGIENE SCHOOL

NAME: _____

ADDRESS: _____

CITY/ST/ZIP: _____

DEAN/DIRECTOR

NAME: _____

PHONE: _____

EMAIL: _____

DENTAL HYGIENE RESTORATIVE EXAM ELIGIBILITY. This is to certify that the following students have successfully completed both the didactic and coursework requirements of their dental hygiene restorative course; and have demonstrated clinical competency sufficient to attempt the WREB Dental Hygiene Restorative Clinical Exam.



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 Restorative Course Completion	WREB DENTAL HYGIENE RESTORATIVE EXAM
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