DENTAL HYGIENE COMMITTEE OF CALIFORNIA

CERTIFICATION IN ADMINISTRATION OF LOCAL ANESTHESIA, NITROUS OXIDE-OXYGEN ANALGESIA, AND PERFORMANCE OF PERIODONTAL SOFT TISSUE CURETTAGE

PLEASE TYPE OR PRINT

COURSE PARTICIPANT NAME

LAST	FIRST	MIDDLE	DATE OF BIRTH ~~LAST 5 DIGITS OF SOCIAL SECURITY~~

ADDRESS		
CITY	STATE	ZIP

HOME PHONE	CELL PHONE	EMAIL ADDRESS
( )	( )	

DENTAL HYGIENE COMMITTEE OF CALIFORNIA (DHCC) COURSE PROVIDER

DATES OF COURSE

ADDRESS (Course provider mailing address is public. If you wish to provide a P.O. Box, you must also provide a physical address and be sure to specify that the physical address is not to be used as the address of record.)

CITY	STATE	ZIP

PHONE

( )

COURSE PROVIDER'S EMAIL ADDRESS

I HEREBY CERTIFY UNDER PENALTY OF PERJURY UNDER THE LAWS OF THE STATE OF CALIFORNIA THAT THE COURSE PARTICIPANT ~~APPLICANT~~ ABOVE SUCCESSFULLY COMPLETED A DHCC-APPROVED COURSE AND DEMONSTRATED CLINICAL COMPETENCY IN THE ABOVE LISTED DUTIES PURSUANT TO CALIFORNIA CODE OF REGULATIONS §~~1108 (i) (1) AND §1108 (i) (2) AND §1108 (i) (3)~~1107(b)(9).

_____

PRINTED NAME OF COURSE INSTRUCTOR OR DIRECTOR

STAMP OR SEAL OF COURSE PROVIDER OR INSTITUTION

_____

SIGNATURE