Application for Dental Hygiene Certification – Administration of Local Anesthesia

Board of Dentistry
P.O. Box 6330
Tallahassee, FL 32314-6330
Fax: (850) 921-5389
Email: MQA.Dentistry@flhealth.gov

Do Not Write in this Space For Revenue Receipting Only

Dental Hygiene Certification - Administration of Local Anesthesia (702) **$35.00**

Fees must be paid in the form of a cashier's check or money order, made payable to the Department of Health. Requests to withdraw or for a refund must be made in writing. Fees are refundable for up to three years from the date of receipt.

1. PERSONAL INFORMATION

Florida Dental Hygiene License Number: _____

Name: _____ **Date of Birth:** _____
Last/Surname First Middle MM/DD/YYYY

Mailing Address: (The address where mail and your license should be sent)

_____ _____ _____
Street/P.O. Box Apt. No. City

_____ _____ _____ _____
State ZIP Country Home/Cell Telephone

Email Notification: To be notified of the status of your application by email, check the "Yes" box and fill in your email address on the line provided. If you choose to be notified via email you will be responsible for checking your email regularly and updating your email address with the board office.

Yes No Email Address: _____

Under Florida law, email addresses are public records. If you do not want your email address released in response to a public records request, do not provide an email address or send electronic mail to our office. Instead contact the office by phone or in writing.

2. EDUCATION HISTORY

A. Provide the following information for the course taken in administration of local anesthesia.

Program/School Name	Address	Date of Completion (MM/DD/YYYY)

Provide proof of course completion as defined in section 466.017(5), Florida Statutes.

B. Have you received training and hold current certification from the American Heart Association, the American Red Cross, or entity with equivalent requirements in cardiopulmonary resuscitation (CPR) at the basic or advanced cardiac life support level, including one-rescuer and two-rescuer CPR for adults, children, and infants; the use of an automatic external defibrillator (AED); and the use of ambu-bags? Yes No

American Heart Association	Certification #:
American Red Cross	Issue Date (MM/DD/YYYY):
Other: _____	Expiration Date (MM/DD/YYYY):

All supporting documentation not attached to and included with this application may be submitted separately to the board office at:

Board *of* Dentistry
4052 Bald Cypress Way Bin C-04
Tallahassee, FL 32399-3258

Signature _____ Date _____
You may print this application and sign it or sign digitally. MM/DD/YYYY