FLORIDA DEPARTMENT OF HEALTH BOARD OF DENTISTRY	**APPLICATION FOR DENTAL HYGIENE CERTIFICATION - ADMINISTRATION OF LOCAL ANESTHESIA** Attach $35.00 Check or Money Order Payable to the Department of Health *AND* -Proof of course completion as defined in s. 466.017(5), F.S. -Proof of certification in either basic cardiopulmonary resuscitation for health professionals or advanced cardiac life support as defined in s. 466.017, F.S.	DO NOT WRITE IN THIS SPACE FOR OFFICE USE ONLY **(Client 702)**

1. APPLICANT PROFILE DATA

➢Please print or type or Application will be returned

Name:	Last First Middle	Primary Telephone: Area Code ( )	Secondary Telephone: Area Code ( )
Mailing Address	Street and No. Apt. No.	Email Address (optional)	
	City State Zip	Florida Dental Hygiene License # _____	

2. COURSE COMPLETION INFORMATION

Name of School/Program Date of Completion

City State

_____

Applicant Signature Date

MAILING ADDRESS:
DEPARTMENT OF HEALTH
P. O. BOX 6330
TALLAHASSEE, FL 32314-6330

DH-MQA 1261, 5/12, Rule 64B5-14.003, FAC