



CERTIFICATION OF DENTAL HYGIENE CLINICAL PRACTICE

The undersigned certifies that _____;
Full name of Applicant
 practiced dental hygiene for the following number of hours and in the following months:

YEAR:		YEAR:		YEAR:		YEAR:		YEAR:	
	# HOURS		# HOURS		# HOURS		# HOURS		# HOURS
JAN		JAN		JAN		JAN		JAN	
FEB		FEB		FEB		FEB		FEB	
MAR		MAR		MAR		MAR		MAR	
APR		APR		APR		APR		APR	
MAY		MAY		MAY		MAY		MAY	
JUN		JUN		JUN		JUN		JUN	
JUL		JUL		JUL		JUL		JUL	
AUG		AUG		AUG		AUG		AUG	
SEPT		SEPT		SEPT		SEPT		SEPT	
OCT		OCT		OCT		OCT		OCT	
NOV		NOV		NOV		NOV		NOV	
DEC		DEC		DEC		DEC		DEC	
YEAR TOTAL		YEAR TOTAL		YEAR TOTAL		YEAR TOTAL		YEAR TOTAL	

I certify under penalty of perjury under the laws of the State of California that I am the custodian of records of the business listed below, and that the above is a true and correct representation of the records of the business.

 SIGNATURE OF PERSON CERTIFYING

 DATE OF SIGNING

 PRINTED NAME OF PERSON CERTIFYING

 POSITION/AUTHORITY OF PERSON CERTIFYING

 BUSINESS NAME

 STREET ADDRESS

 SUITE #

() _____
 TELEPHONE NUMBER

 CITY

 STATE

 ZIP CODE

() _____
 FAX NUMBER