



REQUEST FOR CERTIFICATION OF LICENSE

<p><i>For Office Use Only:</i> Cashiering No.: _____ Prepared by: _____ Date: _____ Mailed: _____</p>
--

\$50.00 FEE REQUIRED
For each request

Please type or print clearly in ink. Be sure to provide all information.

VITAL INFORMATION

Current Name: _____

Prior Last Name(s): _____

License Number _____ Social Security No. _____

Address of Record _____

City _____ State _____ Zip Code _____

Residence Phone: () _____

Address you wish the certification to be sent:

DECLARATION: I authorize the Dental Hygiene Board of California to send a certification of my California auxiliary license to the address above.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct. This declaration is executed on the _____ day of _____ 20_____.

Signature _____

Please send the completed form and payment to the Board's address above and allow 4-6 weeks for your certification request to be processed.