



**CERTIFICATION OF SUCCESSFUL COMPLETION OF REMEDIAL  
 EDUCATION REQUIREMENTS FOR RE-EXAMINATION ELIGIBILITY**

**To be completed by Applicant:** *(Please print legibly or type)*

Applicant Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: ( ) \_\_\_\_\_ SS#: \_\_\_\_\_

**To be completed by University:**

University Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: ( ) \_\_\_\_\_

Course Title	Type of Course* (Circle)	Hours Earned	Date Completed
	C D L		
	C D L		
	C D L		
	C D L		
	C D L		

**\* Key for Type of Course: C = Clinic; D = Didactic; L = Laboratory**

I hereby certify that the individual named above has successfully completed the above course(s) for remedial education requirements in order to become eligible for re-examination for the California Dental Licensure Examination.

(SEAL OF COLLEGE  
 OR UNIVERSITY)

\_\_\_\_\_  
 [SIGNATURE OF DEAN]

\_\_\_\_\_  
 [DATE]