Continuing Education Record for Dentists and Dental Hygienists

Reporting Period – _____ through _____
MM/DD/YYYY MM/DD/YYYY

Please attach proof of each continuing education program/credit & your CPR card. Duplicate page as needed.

_____ _____ _____
Name (Please print or type) License Number Email Address

Date	Course Title	Total Hours (Please Specify) S – Scientific N - Non-Scientific	Sponsor	On-site or Not on-site (Please specify) O – On site N – Not on site	If you have an anesthesia permit, please check √ the line if the hours are to be be used to meet the CE requirement for permit holders.

CPR Type – Please check all that apply & provide copy of card(s) ( )CPR ( )ACLS ( )PALS

Total Hours_____ Number of pages submitted_____

I certify this to be a true and correct record of my continuing education activity for the above specified period.

Signature_____ Date_____

Fax this form and the documentation of continuing education hours obtained to 470-386-6137.