**FORM 2**

**DENTAL HYGIENIST**

The University of the State of New York
THE STATE EDUCATION DEPARTMENT
Office of the Professions
Division of Professional Licensing Services
89 Washington Avenue
Albany, NY 12234-1000

# CERTIFICATION OF PROFESSIONAL EDUCATION

## REGISTERED OR ACCREDITED PROGRAMS

### APPLICANT INSTRUCTIONS

1. Complete Section I in ink. Be sure to enter your name as it appears on your Licensure Application (Form 1) and sign and date the authorization in item 8.
2. Send this form to the institution where you completed a New York State registered licensure-qualifying or American Dental Association, Commission on Dental Accreditation accredited dental hygiene program. Be sure to include any fee required by the school.
3. The institution which completes Section II must send this form directly to the Division of Professional Licensing Services at the address at the end of this form. It will not be accepted if submitted by the applicant.

### SECTION I: APPLICANT INFORMATION

**1** SOCIAL SECURITY NUMBER ___ - ___ - ____

*(Leave this blank if you do not have a U.S. Social Security Number)*

**2** BIRTH DATE ____ ____ ____
*Month Day Year*

**3** PRINT FULL NAME EXACTLY AS IT APPEARS ON YOUR LICENSURE APPLICATION (FORM 1)

Last
First
Middle

**4** MAILING ADDRESS You must notify the Department promptly of any address or name changes.

Line 1
Line 2
Line 3
City
State Zip Code
Country/ Province

**5** Print name under which degree or diploma was awarded: _____

**6** Postsecondary/Preprofessional institution attended: _____

**7** Professional school attended: _____

Address: _____ Date diploma was awarded: ____ / ____ / ____
*mo. day yr.*

**8** I request and give my permission to the institution named in item 7 above to complete the information on this form and send any documentation requested, including that requested on this form (e.g. an official transcript), to the New York State Education Department.

Applicant's signature: _____ Date: ____ / ____ / ____
*mo. day yr.*

## SECTION II : CERTIFICATION OF EDUCATION

**INSTRUCTIONS TO REGISTRAR:** Please complete Section II, sign and date the certification and return this form **directly** to the Division of Professional Licensing Services at the address at the end of this form. DO NOT return this form to the applicant. It will not be accepted if it is incomplete or if it is returned by the applicant.

**1** Name of applicant: _____

**2** Prior to matriculation in professional school, did the applicant obtain a high school diploma or a GED? ☐ **YES** ☐ **NO**

**3** Did the applicant satisfactorily complete a course of study in dental hygiene registered as licensure-qualifying by the New York State Education Department or accredited by the American Dental Association? ☐ **YES** ☐ **NO**

**4** Date degree/certificate of graduation was awarded: _____ List degree granted _____

**5** **CERTIFICATION**

**NOTE: Certification by the school is not acceptable unless dated after graduation.**

I hereby certify that to the best of my knowledge and belief the information in Section II is a true statement of the record of the professional education of the individual named on this form.

Signature of Registrar: _____ Date: _____ / _____ / _____
mo. day yr.

Print or type name: _____

Title or official position: _____

Institution: _____

Address: _____ **(INSTITUTION SEAL)**

_____

Telephone number: ( _____ ) _____

Fax number: ( _____ ) _____

E-Mail: _____

**RETURN DIRECTLY TO:** → **New York State Education Department, Office of the Professions, Division of Professional Licensing Services, Dental Hygiene Unit, 89 Washington Avenue, Albany, NY 12234-1000.**