

NEW MEXICO BOARD OF DENTAL HEALTH CARE

**AFFIDAVIT OF LOCAL ANESTHESIA ADMINISTRATION**  
(Certification by Credentials - ONLY)

Name of Dental Hygienist: \_\_\_\_\_

License #: \_\_\_\_\_

I \_\_\_\_\_, New Mexico licensed dentist, License # \_\_\_\_\_,  
(please print your name)

hereby certify that the dental hygienist listed above has administered local anesthesia under my indirect supervision for a period of not less than two (2) years, and has been observed administering local anesthesia in at least twenty (20) cases/patients over that time. I further certify that the applicant is proficient and qualified to administer local anesthesia under the general supervision of a dentist and that the dental hygienist has demonstrated the ability to handle possible emergencies and side effects of local anesthesia administration, in accordance with the guidelines and rules of the New Mexico Board of Dental Health Care. I have personally evaluated this candidate to ensure the criteria provided by the New Mexico Board of Dental Health Care have been met. I find this candidate acceptable for certification to administer local anesthesia under general supervision.

SIGNED: \_\_\_\_\_

DATE: \_\_\_\_\_

**RETURN COMPLETED AFFIDAVIT TO:**

NEW MEXICO BOARD OF DENTAL HEALTH CARE  
P.O. BOX 25101  
SANTA FE, NM 87505

Office Use Only:	
Board Delegate	
Date	