| ONE OR TWO DIGIT CANDIDATE NUMBER |
| --- |
| |

## Central Regional Dental Testing Service, Inc.

# LOCAL ANESTHESIA TREATMENT CONSENT FORM

I, _____, authorize Candidate #_____, an examinee, to perform upon myself local anesthetic injections.

I understand that the candidate may not be a licensed dental hygienist. I further understand that the injections will be performed by the candidate as part of an examination conducted by Central Regional Dental Testing Service, Inc. to determine the qualification of the candidate for licensure. I recognize that CRDTS personnel will be shown and informed of my medical information which could be pertinent to the procedures I receive during the examination.

The nature and purpose of the procedures as well as the risks and possible complications have been explained to me. My questions regarding the procedures have been answered. I acknowledge that no guarantee or warranty has been made as to the results to be obtained.

I consent to having CRDTS personnel take photographs and film the procedures being performed today provided my name is not in any way associated with these photographs or filming.

I understand that as part of this examination it will be necessary to administer anesthetics and I consent to the use of such anesthetics by the candidate.

_____

Patient's Signature

_____

Patient's Address, City, State, Zip Code

_____

Patient's Phone Number Date