Wisconsin Department of Safety and Professional Services

Office Location: 4822 Madison Yards Way
Madison, WI 53705
Phone Number: (608) 266-2112

LicensE Portal: https://license.wi.gov/
Email: dsps@wisconsin.gov
Website: http://dsps.wi.gov

DENTISTRY EXAMINING BOARD

FACULTY DENTIST CERTIFICATION OF OFFER OF EMPLOYMENT

APPLICANT: Complete this section and submit to certifying school for completion. Form must be returned directly from the school to the Department.

Last Name: | **First Name:** | **MI:** | **Former / Maiden Name(s):**

Address (number/street, city, state, zip code, country):

Date of Birth (mm/dd/yyyy): __/__/____

Social Security Number: (voluntary-for use by school to locate your records) ___-___-____

Application Number:

ATTESTATION OF APPLICANT: I declare that I am the person referred to on this form and that all information required to be completed by me (the applicant for a credential), is complete and accurate to the best of my knowledge and belief. Furthermore, I declare that after completing the information that was required by me (and only that information) the form was forwarded to the relevant third-party for completion of the information asked of them. I also declare that to the best of my knowledge the completed form was provided to the Department of Safety and Professional Services by the relevant third-party (and not by me, the applicant). Finally, I declare that I understand that failure to provide the requested information, making any materially false statement and/or giving any materially false information in connection with my application for a credential may result in credential application processing delays; denial, revocation, suspension, or limitation of my credential; or any combination thereof; or such other penalties as may be provided by law. By signing below, I am signifying that I have read and understand the above declarations. I hereby authorize the school/course provider named below to provide the Department with the information requested below. I hereby authorize the school named below to provide the Department with the information requested below.

Applicant Signature (If unable to provide a digital signature, print and sign form.) **Date** __/__/____

THIS SECTION MUST BE COMPLETED BY THE DEAN OF A WISCONSIN SCHOOL OF DENTISTRY. Complete this section for the above-named applicant and return directly to the Department using the LicensE Third-Party* Upload Portal at license.wi.gov. You will need the application number shown above. (*For form completion purposes, the term "Third-Party" refers to any non-applicant or non-DSPS individual or entity submitting required documentation in support of a credential application.)

School Name

School Address (number/street) (city) (state) (zip code)

Printed Name of Dean

I hear certify that _____ **D.D.S./D.M.D.**
(Name of Applicant)
has been offered employment as a **full-time** faculty member at the above-named dental school effective __/__/____.

ATTESTATION OF THIRD-PARTY PROVIDING INFORMATION RELATED TO APPLICANT: I declare, on behalf of the third-party asked to provide information related to the applicant identified on this form, that the information provided is true and correct to the best of my knowledge and belief. I further declare that after completing the form I, or other third-party staff, will provide the completed form directly to the Wisconsin Department of Safety and Professional Services for review. By signing below, I am signifying that I have read, understand, and have complied with the above declarations.

Signature of Dean (If unable to provide a digital signature, print and sign form.) **Date** __/__/____

Title **Phone** ___-___-____ Ext_____