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

CERTIFICATE OF INFERIOR ALVEOLAR INJECTION

Pursuant to Wis. Admin. Code § DE 7.05(3)(c), a dental hygienist who is employed and taking a local anesthesia program *as continuing education* **outside** of the initial accredited dental hygiene program, may perform the required administration of local anesthesia on a non−classmate at the place where the dental hygienist is employed.

DENTAL HYGIENE APPLICANT Complete this section and submit to supervising dentist. **Form must be returned directly from the supervising dentist to the Department.**

Last Name	First Name	MI	Former / Maiden Name(s)

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 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 __/__/____

SUPERVISING DENTIST 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.)

Name of Practice

Number/Street	City	State	Zip Code

Daytime Phone Number ___-___-____

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.

I certify that while under my supervision, the above-named applicant has successfully completed an inferior alveolar injection on a non-classmate individual, who was informed of the procedure and granted his/her consent to the dentist. The inferior alveolar injection was completed within six (6) weeks from the time the licensed dental hygienist completed his/her coursework; or within 6 weeks of becoming licensed as a dental hygienist in the state of Wisconsin if licensed by endorsement from another state.

Typed Name of Supervising Dentist

Credential Number

Signature of Supervising Dentist (If unable to provide a digital signature, print and sign form.)

Date __/__/____