Wisconsin Department of Safety and Professional Services

Office Location: 4822 Madison Yards Way
Madison, WI 53705
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LicensE Portal: https://license.wi.gov
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DENTISTRY EXAMINING BOARD

ANESTHESIA OR CONSCIOUS SEDATION EDUCATION VERIFICATION FORM

APPLICANT: Complete this section and submit to the certifying body (school, Board, program, or course provider) to verify education. Form must be returned directly from the certifying body to the Department. Note: Higher class levels encompass the authorizations of the lower levels. For example, a dentist who holds a Class III sedation permit does not have to obtain any other sedation permit and a dentist who holds a Class II-Parenteral permit does not need to obtain a Class II-Enteral permit.

LEVEL OF SEDATION PERMIT APPLYING FOR (select one): ☐ **Class II-Enteral** ☐ **Class II-Parenteral** ☐ **Class III**

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

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

Date of Birth (mm/dd/yyyy)	**Social Security Number** (voluntary-for school's use in locating 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, please print and sign form.)	**Date** (mm/dd/yyyy)
	_____/ _____/__________

AFFIDAVIT FOR CLASS II-ENTERAL

Certifying Body (school, Board, program, or course provider): Complete for one level of sedation (Class II-Enteral, Class II-Parenteral, or Class III) as indicated by the applicant above.) Certify applicant education for the appropriate class level 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 School/Board:				
Location of School/Provider:	**City**		**State**	

I ATTEST TO THE FACT THAT THE ABOVE-NAMED APPLICANT: (Complete one option and sign and date below.)

☐ has completed a minimum of 18-hours of training in administration and management of moderate sedation education and training that includes 20 clinical cases (which may include group observation cases) and meets requirements under Wis. Admin. Code § DE 11.035. (ATTACH detailed course content and descriptions.)	**Completion Date** (mm/dd/yyyy) _____/ _____/__________
☐ has completed an oral and maxillofacial surgery residency program accredited by the American Dental Association Commission on Dental Accreditation or its successor agency.	**Completion Date** (mm/dd/yyyy) _____/ _____/__________
☐ is currently American Board of Oral and Maxillofacial Surgery certified or is a candidate for certification.(Check appropriate box to the right.)	☐ **Certified** or ☐ **Candidate for Certification**
☐ is a diplomate or candidate of the American Dental Board of Anesthesiology. (Check appropriate box to the right.)	☐ **Diplomate** or ☐ **Candidate**

AFFIDAVIT FOR CLASS II-ENTERAL ***Continued on next page.***

AFFIDAVIT FOR CLASS II-ENTERAL *Continued.*

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 (If unable to provide a digital signature, please print and sign form.)	**Date** (mm/dd/yyyy)
	_____/ _____/_________
Printed Name	**Phone Number**
Title	

AFFIDAVIT FOR CLASS II-PARENTERAL

Certifying Body (school, Board, program, or course provider): Complete for one level of sedation (Class II-Enteral, Class II-Parenteral, or Class III) as indicated by the applicant at the top of page 1.) Certify applicant education for the appropriate class level and 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 School/Board:					
Location of School/Provider:	**City**		**State**		

I ATTEST TO THE FACT THAT THE ABOVE-NAMED APPLICANT: (Complete one option and sign and date below.)

☐ has completed a minimum of 60-hours of training in administration and management of moderate sedation education and training that includes 20 clinical cases that includes 20 clinical individually managed cases and meets requirements under Wis. Admin. Code § DE 11.035. (ATTACH detailed course content and descriptions.)	**Completion Date** (mm/dd/yyyy) _____/ _____/_________
☐ has completed an oral and maxillofacial surgery residency program accredited by the American Dental Association Commission on Dental Accreditation or its successor agency.	**Completion Date** (mm/dd/yyyy) _____/ _____/_________
☐ is currently American Board of Oral and Maxillofacial Surgery certified or is a candidate for certification.(Check appropriate box to the right.)	☐ **Certified** or ☐ **Candidate for Certification**
☐ is a diplomate or candidate of the American Dental Board of Anesthesiology. (Check appropriate box to the right.)	☐ **Diplomate** or ☐ **Candidate**

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 (If unable to provide a digital signature, please print and sign form.)	**Date** (mm/dd/yyyy)
	_____/ _____/_________
Printed Name	**Phone Number**
Title	

AFFIDAVIT FOR CLASS III *See Page 3.*

Wisconsin Department of Safety and Professional Services

AFFIDAVIT FOR CLASS III				
Certifying Body (school, Board, program, or course provider): Complete for one level of sedation (Class II-Enteral, Class II-Parenteral, or Class III) as indicated by the applicant at the top of page 1.) Certify applicant education for the appropriate class level and 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 School/Board:				
Location of School/Provider:	**City**		**State**	

I ATTEST TO THE FACT THAT THE ABOVE-NAMED APPLICANT: (Complete one option and sign and date below.)	
☐ has completed a postdoctoral residency dental anesthesiology program accredited by the American Dental Association Commission on Dental Accreditation or its successor agency.	**Completion Date** (mm/dd/yyyy) ____/ ____/________
☐ has completed an oral and maxillofacial surgery residency program accredited by the American Dental Association Commission on Dental Accreditation or its successor agency.	**Completion Date** (mm/dd/yyyy) ____/ ____/________
☐ is currently American Board of Oral and Maxillofacial Surgery certified or is a candidate for certification.(Check appropriate box to the right.)	☐ **Certified** or ☐ **Candidate for Certification**
☐ is a diplomate or candidate of the American Dental Board of Anesthesiology. (Check appropriate box to the right.)	☐ **Diplomate** or ☐ **Candidate**

Signature (If unable to provide a digital signature, please print and sign form.)	**Date** (mm/dd/yyyy)
	____/ ____/________
Printed Name	**Phone Number**
Title	

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