Wisconsin Department of Safety and Professional Services
Division of Policy Development
4822 Madison Yards Way, 2nd Floor
PO Box 8366
Madison WI 53708-8366

Phone: 608-266-2112
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Tony Evers, Governor
Dawn B. Crim, Secretary

VIRTUAL/TELECONFERENCE
LICENSURE FORMS COMMITTEE
DENTISTRY EXAMINING BOARD

Virtual, 4822 Madison Yards Way, Madison
Contact: Christian Albouras, (608) 266-2112
September 2, 2020

The following agenda describes the issues that the Committee plans to consider at the meeting. At the time of the meeting, items may be removed from the agenda. Please consult the meeting minutes for a record of the actions of the Committee. ***A quorum of the Board may be present during any committee meetings.***

AGENDA

8:00 A.M.

OPEN SESSION – CALL TO ORDER – ROLL CALL

A. Adoption of Agenda (1-2)

B. Approval of Minutes of March 4, 2020 (3)

C. Administrative Matters – Discussion and Consideration

D. Review of Dentistry Licensure Forms – Discussion and Consideration (4-43)
1) Application for Dental License
2) Application for Dental Faculty License
3) Practicing Without Compensation (Dental and Dental Hygiene)
4) Hygiene/Local Anesthesia/Nitrous
5) Forms Update per DE 11 Rule Changes
6) Anesthesia

E. Next Steps

F. Public Comments

ADJOURNMENT

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MEETINGS AND HEARINGS ARE OPEN TO THE PUBLIC, AND MAY BE CANCELLED WITHOUT NOTICE.

Times listed for meeting items are approximate and depend on the length of discussion and voting. All meetings are held at 4822 Madison Yards Way, Madison, Wisconsin, unless otherwise noted. In order to confirm a meeting or to request a complete copy of the board's agenda, please call the listed contact person. The board may also consider materials or items filed after the transmission of this notice. Times listed for the commencement of disciplinary hearings may be changed by the examiner for the convenience of the parties. Interpreters for the

hearing impaired provided upon request by contacting the Affirmative Action Officer, 608-266-2112 or Meeting Staff at 608-266-5439.

LICENSURE FORMS COMMITTEE
DENTISTRY EXAMINING BOARD
MEETING MINUTES
MARCH 4, 2020

PRESENT: Lisa Bahr, RDH, Shaheda Govani, DDS; Wendy Pietz, DDS

STAFF: Christian Albouras, Executive Director; Jameson Whitney, Legal Counsel; Megan Glaeser, Bureau Assistant; and other Department staff

CALL TO ORDER

Wendy Pietz, Chairperson, called the meeting to order at 11:12 a.m. A quorum was confirmed with three (3) board members present.

ADOPTION OF AGENDA

MOTION: Shaheda Govani moved, seconded by Lisa Bahr, to adopt the Agenda as published. Motion carried unanimously.

ADOPTION OF MINUTES OF JANUARY 8, 2020

MOTION: Shaheda Govani moved, seconded by Lisa Bahr, to adopt the Minutes of January 8, 2020 as published. Motion carried unanimously.

ADJOURNMENT

MOTION: Shaheda Govani moved, seconded by Lisa Bahr, to adjourn the meeting. Motion carried unanimously.

The meeting adjourned at 12:09 a.m.

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Wisconsin Department of Safety and Professional Services

Mail To: P.O. Box 8935
Madison, WI 53708-8935
FAX #: (608) 251-3036
Phone #: (608) 266-2112

Office Location: 4822 Madison Yards Way
Madison, WI 53705
E-Mail: dsps@wisconsin.gov
Website: http://dsps.wi.gov

DENTISTRY EXAMINING BOARD

DENTAL LICENSE INFORMATION

The following documents must be on file with the Dentistry Examining Board to complete licensure requirements in the State of Wisconsin and must be on file thirty days prior to the date on which you wish to be granted permanent licensure.

1. **Application for Dental License (Form #512)** Please complete application including applicable fees. Checks or money orders are to be made payable to the Department of Safety and Professional Services.
2. **National Board Score(s)** Original score(s) must be submitted directly from the National Board of Dental Examiners (NBDE). **Both passing and failing scores are required**. Copies sent from applicants are not acceptable. Go to ADA website: http://www.ada.org/dentpin and submit a request to have your results sent electronically to Wisconsin.
3. **Regional Examination Requirements** Original score(s) must be submitted directly from the testing agency. Both passing and failing scores are required. Copies sent from applicants are not acceptable. Contact the testing agency and request that your scores be mailed directly to DSPS at the above address, faxed with fax cover sheet to 608-251-3036, or emailed directly to DSPSCredDentistry@wisconsin.gov.
4. **Certificate of Professional Education (Form #1471)** Have your dental school accredited by the American Dental Association Commission on Dental Accreditation complete this form and submit it (still in the unopened/sealed envelope) along with your application (**Form #512**), or ask the school to mail it directly to DSPS at the above address, fax it, with fax cover sheet, to 608-251-3036, or email it directly to DSPSCredDentistry@wisconsin.gov.
5. **Verification of Licensure in Other State(s) and/or Jurisdiction(s)** You are required to have each state board, jurisdiction, territory of the United States, and/or country in which you have ever been licensed submit letters of verification to the Wisconsin Dentistry Examining Board. The letters must indicate your license number, date of issuance, status, and a statement regarding disciplinary actions. These letters will be required in order to complete your application for licensure.
6. **Examination on Wisconsin Law** An applicant shall successfully complete an online examination on Wisconsin Statutes and Rules relating to the practice of dentistry before a license can be issued in Wisconsin. Examination information will be provided to an applicant after his or her application for licensure has been received at the Department.
7. **Certificate of Proficiency in Cardiopulmonary Resuscitation/AED** Submit a current copy of the front and back of your signed and dated certification card or certificate of Cardiopulmonary Resuscitation (CPR) and Automated External Defibrillator (AED) program completion. See the Wisconsin Department of Health Services (DHS) website https://www.dhs.wisconsin.gov/ems/licensing/cpr.htm for a listing of approved programs.
8. **National Practitioner Data Bank (NPDB)** Go to https://www.npdb.hrsa.gov/. Follow the directions on the website to complete the Self-Query process. If you receive this report electronically directly from the reporting agency, you must forward the original email you received from them with the link to access the report along with the attachment of the original PDF file of the report you downloaded with the link. Please forward the email and the attached report directly to DSPSCredDentistry@wisconsin.gov or mail the original report with the envelope to the above address. Please allow 7-10 business days for processing once received at the Department. Questions regarding this process may be directed to the Data Bank Help Line at 1-800-767-6732.
9. **Convictions and Pending Charges (Form 2252)** Submit form following form instructions, if applicable.
10. **Malpractice Suits or Claims (Form 2829)** Submit form and copies of malpractice suit, court documents with allegations and settlement, if applicable.
11. **Is Name on ALL Credentials the Same?** If not, submit certified copy of marriage certificate, divorce degree, etc.
12. **Temporary Permit (Form 3572)** Submit if applying for a temporary permit. (See page ii for details.)

EXAMINATION CANDIDATES: Applicants who have taken and passed a Board-approved testing service examination within one (1) year immediately preceding application for Wisconsin licensure may apply as an examination candidate.

ENDORSEMENT CANDIDATES: Applicants who hold a valid license in good standing issued by the proper authorities of any other jurisdiction of the United States or Canada and meets requirements listed in Wis. Admin. Code § DE 2.04(1) may apply as an endorsement candidate.

GRADUATES OF FOREIGN DENTAL SCHOOLS: An applicant for a license as a dentist who is a graduate of a foreign dental school shall submit the following to the board evidence of one of the following:

a) Verification of having been awarded a DDS or DMD degree from an accredited dental school, or
b) Verification of having received a dental diploma, degree or certificate from a full time, undergraduate supplemental dental education program of at least two (2) academic years at an accredited dental school. The program must provide didactic and clinical education to the level of a DDS or DMD graduate.

In addition, a graduate of a foreign dental school applying as an **Examination Candidate** must submit evidence satisfactory to the board of having graduated from a foreign dental school and the same information required of non-foreign-trained dentists as listed in Wis. Admin. Code § DE 2.01(1m). A graduate of a foreign dental school applying as an **Endorsement Candidate** must hold a valid license in good standing issued by the proper authorities in any other jurisdiction of the U.S. or Canada and must submit the same information as non-foreign-trained dentists as listed in Wis. Admin. Code § DE 2.04(1).

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Wisconsin Department of Safety and Professional Services

TEMPORARY PERMIT CANDIDATES: A temporary license may be granted to an applicant who meets all of the requirements for licensure except the clinical examination. **A person who has taken the clinical exam and failed is not eligible.**

- A person holding a temporary license is required to practice under the supervision of a licensed dentist. Supervision is defined as a person of immediate availability to coordinate, direct, and inspect the practice of the holder of the temporary license either by being on site or available to collaborate through the use of communication technology.
- The temporary license is valid for a period of 3 months or until the holder receives a regular license or notification of failing the clinical exam.
- If applying for a temporary permit, **Form #3572** is required.

ADDITIONAL INFORMATION

PLEASE NOTE OTHER APPLICATION TYPES AND INFORMATION AVAILABLE ON THE DEPARTMENT'S DENTIST WEBPAGE: https://dsps.wi.gov/Pages/Professions/Dentist/Default.aspx.

- Form 2759, Application for Permit to Administer Anesthesia or Conscious Sedation: Dentists administering anesthesia or sedation, other than nitrous oxide inhalation or anxiolysis, must obtain a permit from the Board.

- Form 2650, Application for Dental Faculty License: Available to applicants who have been offered employment as a full-time faculty member from an accredited post−doctoral dental residency training program or accredited school of dentistry in this state.

- Form 2850, Application to Practice Dentistry without Compensation: A temporary permit for applicants who wish to practice dentistry without compensation for a specific area where services will improve the welfare of Wisconsin residents. The temporary permit will be issued for 10 calendar days during the 12-month period immediately following its effective date unless otherwise approved by the Board.

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DENTISTRY EXAMINING BOARD

DENTAL LICENSE APPLICATION

The Department must deny your application if you are liable for delinquent state taxes, UI contributions, or child support (Wis. Stat. §§ 440.12 and 440.13).

PLEASE TYPE OR PRINT IN INK ☐ Your name, address, telephone number, and e-mail address are available to the public. Check box to withhold address, telephone number, and e-mail address from lists of 10 or more credential holders (Wis. Stat. § 440.14).

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

Address (street, city, state, zip)

Daytime Telephone Number ☐☐☐ - ☐☐☐ - ☐☐☐☐

Mailing Address (if different)

Date of Birth ☐☐ / ☐☐ / ☐☐☐☐

Social Security Number ☐☐☐ - ☐☐ - ☐☐☐☐

Your Social Security Number or Employer Identification Number must be submitted with your application on this form. If you do not have a Social Security Number, you must complete Form #1051. The Department may not disclose the Social Security Number collected except as authorized by law.

Ethnicity/gender status information is optional.

Ethnicity: ☐ White, not of Hispanic origin ☐ Black, not of Hispanic origin ☐ American Indian or Alaskan ☐ Asian or Pacific Islander ☐ Hispanic ☐ Other

Sex: ☐ M ☐ F

Have you ever been licensed in Wisconsin as a Dentist? ☐ Yes ☐ No If yes, list your credential number:

E-mail Address

School Name

School Address (street, city, state, country)

Date Degree Conferred ☐☐ / ☐☐ / ☐☐☐☐

Degree

Specialty

School Name [List other school(s), if applicable. Attach additional sheets if needed.]

School Address (street, city, state, country)

Date Degree Conferred ☐☐ / ☐☐ / ☐☐☐☐

Degree

Specialty

APPLICATION FEES: Please check applicable box. Make check payable to DSPS and attach to this application.

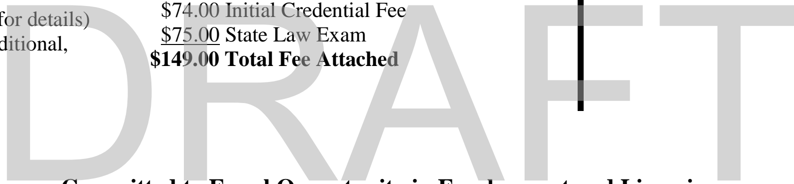
☐ **I am seeking a Veteran Fee Waiver**
(for Initial Credential Fee only, see page 2 for further information)
$00.00 Initial Credential Fee
$75.00 State Law Exam
$75.00 Total Fee Attached

☐ **Temporary Permit Fee** (See pg. ii for details)
$10.00 Temporary Permit Fee (additional, non-refundable fee)

☐ **Exam Applicants**
$74.00 Initial Credential Fee
$75.00 State Law Exam
$149.00 Total Fee Attached

☐ **Endorsement Applicants**
$74.00 Initial Credential Fee
$75.00 State Law Exam
$149.00 Total Fee Attached

For Receipting Use Only (15)



Wisconsin Department of Safety and Professional Services

IMPORTANT NOTE: Application is not complete until all required documents listed on page i of this form (#512) have been received at the Department.

ARE YOU A VETERAN? If yes, please view the Department website at https://dsps.wi.gov/Pages/Professions/MilitaryLicensureBenefits.aspx for eligibility requirements.

If you qualify, are you requesting a waiver of your initial credentialing fee? ☐ Yes ☐ No

If Yes, provide a copy of your Department of Veterans Affairs voucher code and list your DVA Voucher Code Number: ______

If you qualify, are you requesting equivalency of your Military Training and experience? ☐ Yes ☐ No

If Yes, complete and return the Veteran Request Application Addendum (**Form #2996**). This form must be included with this application.

If you qualify, are you requesting Temporary Spousal Reciprocal License? ☐ Yes ☐ No

If Yes, do not complete this form. You must complete and return the Application for Temporary Spousal Reciprocal License (**Form #2982**).

You may contact the DVA at 1-800-WisVets or www.WISVET.com for assistance in obtaining your DVA Voucher Code and/or documents related to your training.

CONTINUING EDUCATION and RENEWAL REQUIREMENTS: View the Department website at http://dsps.wi.gov and select "Professions" then click on the "Dentist" hyperlink.

Have you been tested by a Regional Dental Testing Service? ☐ Yes ☐ No

If yes, submit original score(s) of certification/notification of passing/failing and date.

If yes, please indicate which examination:

☐ The Commission on Dental Competency Assessments (CDCA), Formerly Northern Regional Examining Board (NERB), or ADEX (American Board of Dental Examiners)
☐ Western Regional Examining Board (WREB)
☐ Other (**specify**): ______________________________
☐ Central Regional Dental Testing Score (CRDTS)
☐ Southern Regional Testing Agency (SRTA)
☐ Council of Interstate Testing Agency (CITA)

If no, please explain: ______

Have you taken and passed the National Boards? ☐ Yes ☐ No

If yes, submit original score(s) from the National Boards. (See page i for submission instructions.)

I AM OR HAVE BEEN LICENSED IN THE FOLLOWING STATE(S)/JURISDICTION(S). (Include all active and inactive licenses.)

For each credential listed above, you are required to have each state board, jurisdiction, territory of the United States, and/or country submit a letter of verification to the Wisconsin Dentistry Examining Board. The verification letter(s) must state your date of birth, credential number, date of issuance, and a statement regarding disciplinary actions.

ANSWER THE FOLLOWING QUESTIONS. (Attach additional sheets if necessary.)

1.	Have you ever surrendered, resigned, canceled, or been denied a professional license or other credential in Wisconsin, or any other jurisdiction? **If yes, give details on an attached sheet, including the name of the profession and the agency.**	☐ Yes ☐ No
2.	Have you ever failed to pass any state board examination or national board examination? **If yes, provide details below. (Original pass/fail score(s) required.)**	☐ Yes ☐ No
3.	Has any licensing or other credentialing agency ever taken any disciplinary action against you, including but not limited to any warning, reprimand, suspension, probation, limitation, or revocation? **If yes, attach a sheet providing details about the action, including the name of the credentialing agency and date of action**.	☐ Yes ☐ No
4.	Is disciplinary action pending against you in any jurisdiction? **If yes, attach a sheet providing details about pending action, including the name of the agency and status of action**.	☐ Yes ☐ No

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Wisconsin Department of Safety and Professional Services

ANSWER THE FOLLOWING QUESTIONS. (Attach additional sheets if necessary.)

5.	Have any suits or claims ever been filed against you as a result of professional services? **If yes, submit a copy of the claim or suit and a copy of the final settlement or disposition and complete Malpractice Suits or Claims Form (#2829)**.	☐ Yes ☐ No
6.	Have you failed to pass the Central Regional Dental Testing Service Clinical examination, or any other dental licensing examination? **If yes, state which examination, and the date of the examination. (Original pass/fail score(s) required.)**	☐ Yes ☐ No
7.	Are you registered or licensed in any other profession(s)? **If yes, state what profession(s) and in what state(s):**	☐ Yes ☐ No
8.	Have you ever been credentialed under any other name(s)? **If yes, state name(s) credentialed under:**	☐ Yes ☐ No
9.	Has the Drug Enforcement Administration (DEA) ever withdrawn your DEA number or warned you, or have you been denied a DEA number? **If yes, give details on an attached sheet**.	☐ Yes ☐ No
10.	Have you ever been convicted of a misdemeanor, felony, or other violation of federal, state, or local law or do you have any felony, misdemeanor or other violation of federal, state, or local law charges pending against you in this state or any other? This includes municipal ordinances resulting only in monetary fines or forfeitures and convictions resulting from a plea of no contest, a guilty plea or verdict.	☐ Yes ☐ No
11.	Are you incarcerated, on probation, or on parole for any conviction? **If yes, attach a sheet providing details including the terms of incarceration and a copy of a report from your probation or parole officer**.	☐ Yes ☐ No
12.	If yes to question 10 above, did you apply for a predetermination of a conviction or convictions? **If yes, proceed to question 13.** **If no, submit Convictions and Pending Charges Form #2252 and supporting documentation.**	☐ Yes ☐ No
13.	If yes to question 12 above, did you receive a letter indicating the convictions and pending charges did not disqualify you from licensure? **If yes, proceed to question 14.** **If no, submit Convictions and Pending Charges Form #2252 and supporting documentation.**	☐ Yes ☐ No
14.	If yes to question 13, since the date of the letter indicating you were not disqualified from licensure, have you been convicted of a misdemeanor, felony, or other violation of federal, state, or local law or do you have any felony, misdemeanor or other violation of federal, state, or local law charges pending against you in this state or any other? This includes municipal ordinances resulting only in monetary fines or forfeitures and convictions resulting from a plea of no contest, a guilty plea, or verdict. **If YES, submit Convictions and Pending Charges Form #2252 and supporting documentation for each conviction and pending charge since the date of the letter.** **If NO, submit Convictions and Pending Charges Form #2252 without previously submitted documentation.**	☐ Yes ☐ No

For the purposes of these questions, the following phrases or words have the following meanings:

"Ability to practice dentistry" is to be construed to include all of the following:

1. The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned dentistry judgments and to learn and keep abreast of dentistry developments; and
2. The ability to communicate those judgments and dental information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
3. The physical capability to perform medical tasks such as physical examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.

"Medical Condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, Cerebral Palsy, epilepsy, Muscular Dystrophy, Multiple Sclerosis, cancer, heart disease, Diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction and alcoholism.

"Chemical Substances" is to be construed to include alcohol, drugs, or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

"Currently" does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather, it means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, or **within the past two years.**

"Illegal use of Controlled Dangerous Substances" means the use of controlled dangerous substances obtained illegally (e.g. heroin or cocaine) as well as the use of controlled dangerous substances, which are not obtained pursuant to a valid prescription, or not taken in accordance with the directions of a licensed health care practitioner.

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Wisconsin Department of Safety and Professional Services

AFTER READING THE PARAGRAPH ABOVE, ANSWER THE FOLLOWING QUESTIONS. (Attach additional sheets if necessary.)

15.	Do you have a medical condition which in any way impairs or limits your ability to practice dentistry with reasonable skill and safety? **If yes, please explain**.	☐ Yes ☐ No
16.	**If yes to question 15 above,** are the limitations or impairments caused by your medical condition reduced or ameliorated because you receive ongoing treatment (with or without medications) or participate in a monitoring program? **If yes, please explain**.	☐ Yes ☐ No
17.	**If yes to question 15 above**, are the limitations or impairments caused by your medical condition reduced, or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice? **If yes, please explain**.	☐ Yes ☐ No
18.	Does your use of chemical substance(s) in any way impair, or limit your ability to practice dentistry with reasonable skill and safety? **If yes, please explain**.	☐ Yes ☐ No
19.	Have you ever been diagnosed as having, or have you ever been treated for pedophilia, exhibitionism, or voyeurism? **If yes, please explain**.	☐ Yes ☐ No
20.	Are you currently (within the last 2 years) engaged in the illegal use of controlled dangerous substances? **If yes, please explain**.	☐ Yes ☐ No
21.	**If yes to question 20**, are you currently participating in a supervised rehabilitation program or professional assistance program which monitors you in order to assure that you are not engaging in the illegal use of controlled dangerous substances? **If yes, please explain**.	☐ Yes ☐ No

CERTIFICATION OF LEGAL STATUS

I declare under penalty of law that I am (check one):

☐ A citizen or national of the United States, or

☐ A qualified alien or nonimmigrant lawfully present in the United States who is eligible to receive this professional license or credential as defined in the Personal Responsibility and Work Opportunities Reconciliation Act of 1996, as codified in 8 U.S.C. §1601 et. Seq. (PRWORA). For questions concerning PRWORA status, please contact the U.S. Citizenship and Immigration Services in the Department of Homeland Security at 1-800-375-5283 or online at http://www.uscis.gov.

Should my legal status change during the application process or after a credential is granted, I understand that I must report this change to the Wisconsin Department of Safety and Professional Services immediately.

CONTINUING DUTY OF DISCLOSURE

I understand that I have a continuing duty of disclosure during the application process. If information I have provided in this application becomes invalid, incorrect, or outdated, I understand that I am obliged to provide any necessary information to ensure the information on my application remains current, valid, and truthful. I understand that credentialing authorities may view acts of omission as dishonesty and that my duty of disclosure during the application process exists until licensure is granted or denied.

AFFIDAVIT OF APPLICANT

I declare that I am the person referred to on this application and that all answers set forth are each and all strictly true in every respect. I understand that failure to provide requested information, making any materially false statement and/or giving any materially false information in connection with my application for a credential or for renewal or reinstatement of 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. I further understand that if I am issued a credential, or renewal, or reinstatement thereof, failure to comply with the statutes and/or administrative code provisions of the licensing authority will be cause of disciplinary action.

By signing below, I am signifying that I have read the above statements (Certification of Legal Status, Continuing Duty of Disclosure, and Affidavit of Applicant) and understand the obligation I have as an applicant or credential-holder should information I've provided to the Department of Safety and Professional Services change.

Signature: ____________________ Date: __ __ / __ __ / __ __ __ __

Wisconsin Department of Safety and Professional Services

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DENTISTRY EXAMINING BOARD

REQUEST FOR TEMPORARY LICENSE FOR DENTIST OR DENTAL HYGIENIST

- A temporary license may be granted to an applicant who meets all of the requirements for licensure except the clinical examination. A person who has taken the clinical exam and failed is not eligible.
- A person holding a temporary license is required to practice under the supervision of a licensed dentist. Supervision is defined as a person of immediate availability to coordinate, direct, and inspect the practice of the holder of the temporary license either by being on site or available to collaborate through the use of communication technology.
- The temporary license is valid for a period of three (3) months or until the holder receives a regular license or notification of failing the clinical exam.

Type of license applying for: ☐ Dentist ☐ Dental Hygienist

NAME OF APPLICANT (Please print): ______________________________

Applicant, please check one and forward this form to your supervisor:

☐ I plan to take the next clinical examination for dentist or dental hygienist and wish to begin practicing prior to the date of examination.

☐ I have taken the clinical examination, am awaiting results, and wish to begin practicing prior to the next scheduled board meeting for a permanent license.

AFFIDAVIT OF SUPERVISING DENTIST: **Supervisor may fax or email form directly to DSPS, facility with cover sheet or cover letter, to (608) 251-3036 or DSPSCredDentistry@wisconsin.gov.**

I request that a temporary license to practice as a dentist or dental hygienist in the State of Wisconsin be issued to ______________________________. (Name)

I am aware that this temporary license will expire when the applicant is notified he/she failed the clinical examination, or on the date the board grants or denies an applicant a permanent license.

Signature and Title	Facility Name
Print Name and Wisconsin Dentist Credential #	Street Address
(______) ____________ Phone Number	City and State Zip Code
	Date

#3572 (Rev. 8/20)
Wis. Stat. ch. 447

Committed to Equal Opportunity in Employment and Licensing

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Wisconsin Department of Safety and Professional Services

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DENTISTRY EXAMINING BOARD

DENTAL FACULTY LICENSE APPLICATION INFORMATION

The Dentistry Examining Board shall grant a dental faculty license to an applicant who is **licensed in good standing to practice dentistry in another jurisdiction approved by the Board** upon presentation of the license and who submits the following information to the Board at the above address:

1. **APPLICATION FOR DENTAL FACULTY LICENSE (FORM #2650)** Please complete a current application including all applicable fees. Checks or money orders are to be made payable to the Department of Safety and Professional Services.

2. **VERIFICATION OF LICENSURE IN ANOTHER JURISDICTION** Please request the state/country board where you hold a current dental license to submit a letter of verification to the Wisconsin Dentistry Examining Board. This letter must indicate your license number, date of issuance, status, and a statement regarding disciplinary actions. This letter is required in order to complete your application for licensure.

3. **CERTIFICATE OF PROFICIENCY IN CARDIOPULMONARY RESUSCITATION/AED** Submit a current copy of the front and back of your signed and dated certification card or certificate of Cardiopulmonary Resuscitation (CPR) and Automated External Defibrillator (AED) program completion. See the Wisconsin Department of Health Services (DHS) website https://www.dhs.wisconsin.gov/ems/licensing/cpr.htm for a listing of approved programs.

4. **NATIONAL PRACTITIONER DATA BANK** Go to https://www.npdb.hrsa.gov/. Follow the directions on the website to complete the Self- Query process. If you receive this report electronically directly from the reporting agency, you must forward the original email you received from them with the link to access the report along with the attachment of the original PDF file of the report you downloaded with the link. Please forward the email and the attached report directly to DSPSCredDentistry@wisconsin.gov or mail the original report with the envelope to the above address. Please allow 7-10 business days for processing once received at the Department. Questions regarding this process may be directed to the Data Bank Help Line at 1-800-767-6732.

5. **FACULTY DENTIST CERTIFICATION OF OFFER OF EMPLOYMENT (Form #2653)** Complete this form following form instructions and have the school submit directly to the Department.

6. **INITIAL INTERVIEW** Once items 1-5 are complete, this application will be submitted for initial review. You may be scheduled to appear before the Board at the next regularly scheduled meeting.

7. **CONVICTIONS AND PENDING CHARGES** (**Form #2252**) Submit form following form instructions, if applicable.

8. **MALPRACTICE SUITS OR CLAIMS** (**Form #2829**) Submit form and copies of malpractice suit(s), court documents with allegations and settlement(s), if applicable.

9. **IS NAME ON ALL CREDENTIALS THE SAME?** If not, submit certified copy of marriage certificate, divorce decree, etc.

Please see Wisconsin Administrative Code § DE 2.015 for further information about the Dental Faculty License.

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Wisconsin Department of Safety and Professional Services

Mail To: P.O. Box 8935
Madison, WI 53708-8935
FAX #: (608) 251-3036
Phone #: (608) 266-2112

Office Location: 4822 Madison Yards Way
Madison, WI 53705
E-Mail: dsps@wisconsin.gov
Website: http://dsps.wi.gov

DENTISTRY EXAMINING BOARD

APPLICATION FOR DENTAL FACULTY LICENSE

The Department must deny your application if you are liable for delinquent state taxes, UI contributions, or child support (Wis. Stat. §§ 440.12 and 440.13).

PLEASE TYPE OR PRINT IN INK ☐ Your name, address, telephone number and email address are available to the public. Check box to withhold address, telephone number, and email address from lists of 10 or more credential holders (Wis. Stat. § 440.14).

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

Address (street, city, state, zip)

Daytime Telephone Number ___ - ___ - ____

Mailing Address (if different)

Date of Birth __ / __ / ____

Social Security Number ___ - __ - ____

Your Social Security Number or Employer Identification Number must be submitted with your application on this form. If you do not have a Social Security Number, you must complete Form #1051. The Department may not disclose the Social Security Number collected except as authorized by law.

Ethnicity/gender status information is optional.

Ethnicity: ☐ White, not of Hispanic origin ☐ American Indian or Alaskan ☐ Hispanic
☐ Black, not of Hispanic origin ☐ Asian or Pacific Islander ☐ Other

Sex: ☐ M ☐ F

Have you ever been licensed in Wisconsin as a Dentist? ☐ Yes ☐ No If yes, list your credential number:

Email Address

School Name

School Address (street, city, state, country)

Date Degree Conferred __ / __ / ____

Degree

Specialty

School Name [List other school(s), if applicable. Attach additional sheets if needed.]

School Address (street, city, state, country)

Date Degree Conferred __ / __ / ____

Degree

Specialty

APPLICATION FEES: Please check applicable box. Make check payable to DSPS and attach to this application.

☐ **I am seeking a Veteran Fee Waiver**
(for Initial Credential Fee only, see page 2 for further information)

☐ **Faculty Dentist Applicants**
$59.00 Initial Credential Fee
$59.00 Total Fee Attached

For Receipting Use Only (875)

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#2650 (Rev. 4/20)
Wis. Stat. ch. 447

Committed to Equal Opportunity in Employment and Licensing

Wisconsin Department of Safety and Professional Services

<u>IMPORTANT NOTE</u>: **YOUR APPLICATION IS NOT COMPLETE UNTIL ALL REQUIRED DOCUMENTS LISTED ON PAGE i OF THIS FORM (#2650) HAVE BEEN RECEIVED.**

ARE YOU A VETERAN? If yes, please view the Department website at https://dsps.wi.gov/Pages/Professions/MilitaryLicensureBenefits.aspx for eligibility requirements.

If you qualify, are you requesting a waiver of your initial credentialing fee? ☐ Yes ☐ No

If Yes, provide a copy of your Department of Veterans Affairs voucher code and list your DVA Voucher Code Number: ______

If you qualify, are you requesting equivalency of your Military Training and experience? ☐ Yes ☐ No
If Yes, complete and return the Veteran Request Application Addendum (**Form #2996**). This form must be included with this application.

If you qualify, are you requesting Temporary Spousal Reciprocal License? ☐ Yes ☐ No

<u>If Yes, do not complete this form</u>. You must complete and return the Application for Temporary Spousal Reciprocal License (**Form #2982**).
You may contact the DVA at 1-800-WisVets or www.WISVETS.com for assistance in obtaining your DVA Voucher Code and/or documents related to your training.

<u>**ANSWER THE FOLLOWING QUESTIONS**</u> [Attach additional sheet(s) if necessary.]:

1.	Have you ever surrendered, resigned, canceled, or been denied a professional license or other credential in Wisconsin, or any other jurisdiction? **If yes, give details on an attached sheet, including the name of the profession and the agency.**	☐ Yes ☐ No
2.	Have you ever failed to pass any state board examination or national board examination? **If yes, provide details below: (Original pass/fail scores required.)** ______	☐ Yes ☐ No
3.	Has any licensing or other credentialing agency ever taken any disciplinary action against you, including but not limited to any warning, reprimand, suspension, probation, limitation, or revocation? **If yes, attach a sheet providing details about the action, including the name of the credentialing agency and date of action.**	☐ Yes ☐ No
4.	Is disciplinary action pending against you in any jurisdiction? **If yes, attach a sheet providing details about pending action, including the name of the agency and status of action.**	☐ Yes ☐ No
5.	Have you ever been convicted of a misdemeanor or a felony, or do you have any felony or misdemeanor charges pending against you? **If yes, submit Convictions and Pending Charges (Form #2252).**	☐ Yes ☐ No
6.	Are you incarcerated, on probation, or on parole for any conviction? **If applicable, attach a sheet providing details including the terms of incarceration and a copy of a report from your probation or parole officer.**	☐ Yes ☐ No
7.	Have any suits or claims ever been filed against you as a result of professional services? **If yes, submit a copy of the claim or suit and a copy of the final settlement or disposition and complete Malpractice Suits or Claims Form (#2829).**	☐ Yes ☐ No
8.	Have you failed to pass the Central Regional Dental Testing Service Clinical examination, or any other dental licensing examination? **If yes, state which examination, and the date of the examination. (Original pass/fail scores required.)** ______	☐ Yes ☐ No
9.	Are you registered or licensed in any other profession(s)? **If yes, state what profession(s) and in what state(s):** ______	☐ Yes ☐ No
10.	Have you ever been credentialed under any other name(s)? **If yes, state name(s) credentialed under:** ______	☐ Yes ☐ No
11.	Has the Drug Enforcement Administration (DEA) ever withdrawn your DEA number or warned you, or have you been denied a DEA number? **If yes, give details on an attached sheet.**	☐ Yes ☐ No

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Wisconsin Department of Safety and Professional Services

CERTIFICATION OF LEGAL STATUS:

I declare under penalty of law that I am (check one):

☐ A citizen or national of the United States, **or**

☐ A qualified alien or nonimmigrant lawfully present in the United States who is eligible to receive this professional license or credential as defined in the Personal Responsibility and Work Opportunities Reconciliation Act of 1996, as codified in 8 U.S.C. §1601 et. Seq. (PRWORA). For questions concerning PRWORA status, please contact the U.S. Citizenship and Immigration Services in the Department of Homeland Security at 1-800-375-5283 or online at http://www.uscis.gov , **or**

☐ I do not currently have a VISA. I am applying for a VISA as I am applying for a faculty dentist license and have been offered employment as a full-time faculty member from an accredited post−doctoral dental residency training program or accredited school of dentistry in this state.

Should my legal status change during the application process or after a credential is granted, I understand that I must report this change to the Wisconsin Department of Safety and Professional Services immediately.

CONTINUING DUTY OF DISCLOSURE

I understand that I have a continuing duty of disclosure during the application process. If information I have provided in this application becomes invalid, incorrect or outdated, I understand that I am obliged to provide any necessary information to ensure the information on my application remains current, valid, and truthful. I understand that credentialing authorities may view acts of omission as dishonesty and that my duty of disclosure during the application process exists until licensure is granted or denied.

AFFIDAVIT OF APPLICANT

I declare that I am the person referred to on this application and that all answers set forth are each and all strictly true in every respect. I understand that failure to provide requested information, making any materially false statement and/or giving any materially false information in connection with my application for a credential or for renewal or reinstatement of 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. I further understand that if I am issued a credential, or renewal, or reinstatement thereof, failure to comply with the statutes and/or administrative code provisions of the licensing authority will be cause of disciplinary action.

By signing below, I am signifying that I have read the above statements (Certification of Legal Status, Continuing Duty of Disclosure, and Affidavit of Applicant) and understand the obligation I have as an applicant or credential-holder should information I've provided to the Department of Safety and Professional Services change.

Applicant Signature: ____________________ Date: __ __ / __ __ / __ __ __ __

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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: (street, city, state, zip code, country)

Date of Birth: __ __ / __ __ / __ __ __ __

Social Security #: (voluntary-for use by school to locate your records) __ __ __ - __ __ - __ __ __ __

I hereby authorize the school named below to provide the Department with the information requested below.

Applicant Signature | **Date** __ __ / __ __ / __ __ __ __

THIS SECTION MUST BE COMPLETED BY THE DEAN OF A WISCONSIN SCHOOL OF DENTISTRY
School may fax/email completed form with school cover sheet/letter to: (608) 251-3036 or DSPSCredDentistry@wisconsin.gov.

School Name:

School Address (street, city, state, zip code):

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 __ __ / __ __ / __ __ __ __

Signature of Dean | **Date** __ __ / __ __ / __ __ __ __

School Seal

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DENTISTRY EXAMINING BOARD

INFORMATION FOR PERMIT TO ADMINISTER ANESTHESIA OR CONSCIOUS SEDATION

INSTRUCTIONS: A dentist may not administer anesthesia or sedation without a permit at the appropriate level of anesthesia or sedation. Permit levels of sedation are aligned with American Dental Association guidelines. When completing the application, complete the section that corresponds to the desired class level permit: Class II-Enteral; Class II-Parenteral; or Class III.

Minimal sedation does not require a permit. This includes:

- Nitrous oxide inhalation utilizing adequate equipment with failsafe features and a 25% minimum oxygen flow in an outpatient setting (Wis. Admin. Code § DE 11.03(1)), and/or
- Anxiolysis (Wis. Admin. Code § DE 11.03(2)).

IMPORTANT NOTE: Nitrous oxide when used in combination with a sedative agent may produce minimal, moderate, or deep sedation. During the administration of moderate or nitrous oxide oxygen sedation, if a patient enters a deeper level of sedation than the dentist is authorized by permit to provide, then the dentist shall stop the sedation and dental procedures until the patient returns to the intended level of sedation (Wis. Admin. Code § DE 11.03).

Class I permit: Class I permits issued prior to September 1, 2020 are no longer valid and a Class II-Enteral or Class II-Parenteral permit is required to provide moderate sedation. As of September 1, 2020 a dentist holding a Class I permit may apply for a Class II-Enteral or Class II-Parental permit OR shall be granted a Class II-Enteral permit upon evidence of twenty (20) cases providing moderate sedation within the last five (5) years. Please refer to definitions in Wis. Admin. Code ch. DE 11.

Class II permit: A dentist holding a Class II permit on September 1, 2020 shall be given a Class II-Parenteral permit. Please refer to definitions in Wis. Admin. Code ch. DE 11.

Class II-Enteral permit: allows a dentist to administer moderate sedation by enteral route (Wis. Admin. Code § DE 11.02 (1t)). Please refer to definitions in Wis. Admin. Code ch. DE 11.

Class II-Parenteral permit: allows a dentist to administer moderate sedation by parenteral route (Wis. Admin. Code § DE 11.02 (1tm)). Please refer to definitions in Wis. Admin. Code ch. DE 11.

Class III permit: allows a dentist to administer moderate sedation, deep sedation, or general anesthesia. Please refer to definitions in Wis. Admin. Code ch. DE 11.

Continuing education and renewal requirements are avaible on the Department website at http://dsps.wi.gov. Select "Professions," then "Dentist."

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DENTISTRY EXAMINING BOARD

APPLICATION FOR PERMIT TO ADMINISTER ANESTHESIA OR CONSCIOUS SEDATION

The Department must deny your application if you are liable for delinquent state taxes, UI contributions, or child support (Wis. Stats. § 440.12 and 440.13).

PLEASE TYPE OR PRINT IN INK

☐ Your name, address, telephone number, and e-mail address are available to the public. Check box to withhold address, telephone number, and e-mail address from lists of 10 or more credential holders (Wis. Stat. § 440.14).

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

Address (street, city, state, zip)	**Daytime Telephone Number**
	___ - ___ - ____
Mailing Address (if different)	**Date of Birth**
	__ / __ / ____

Social Security Number

___ - __ - ____

Your Social Security Number or Employer Identification Number must be submitted with your application on this form. If you do not have a Social Security Number, you must complete Form #1051. The Department may not disclose the Social Security Number collected except as authorized by law.

Ethnicity/gender status information is optional.

Ethnicity: ☐ White, not of Hispanic origin ☐ American Indian or Alaskan ☐ Hispanic
☐ Black, not of Hispanic origin ☐ Asian or Pacific Islander ☐ Other

Sex: ☐ M ☐ F

Email Address

List your Wisconsin Dentist Credential Number:
(Current Wisconsin licensure is required for a sedation permit.)

APPLICATION FEES: Please check applicable box. Make check payable to DSPS and attach to this application.

☐ **$ 75.00 Initial Credential Fee Attached**

For Receipting Use Only (15)

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Wisconsin Department of Safety and Professional Services

CHECK THE BELOW CLASS FOR WHICH YOU ARE SEEKING CERTIFICATION (CLASS III, CLASS II-Parenteral, or CLASS II-Enteral). Within each section is a list of documents required for certification. Your application will not be considered complete until the Department has received all documents.

☐ **CERTIFICATION FOR CLASS III/MODERATE OR DEEP SEDATION OR GENERAL ANESTHESIA:** This permit allows a dentist to provide all of the following: moderate or deep sedation; general anesthesia; conscious sedation-parenteral; and conscious sedation-enteral. Dentists who hold Class III Permits do not have to obtain any other sedation permit.

- ☐ Completed application (**Form #2759**) and fee.
- ☐ Verification of any permit or credential authorizing anesthesia or sedation held by the dentist.
- ☐ Certification in Advanced Cardiovascular Life Support or pediatric Advanced Life Support through a course that follows the American Heart Association guidelines. Pediatric Advanced life Support is required if treating pediatric patients (12 years old or under).
- ☐ Proof of one of the following:
  - Current board certification or a candidate for board certification by the American Board of Oral and Maxillofacial Surgery, **Form #2758 required**; or
  - Completion of an accredited oral and maxillofacial surgery residency, **Form #2758 required**; or
  - Current diplomate or candidate of the American Dental Board of Anesthesiology, **Form #2758 required**; or
  - Postdoctoral residency in an accredited dental program in dental anesthesiology, **Form #2758 required.**

☐ **CERTIFICATION FOR CLASS II-Parenteral:** This permit allows a dentist to provide moderate sedation via parenteral or enteral routes. Dentists who hold a Class II-Parenteral permit do not have to obtain a Class II-Enteral permit.

- ☐ Completed application (**Form #2759**) and fee.
- ☐ Verification of any permit or credential authorizing anesthesia or sedation held by the dentist.
- ☐ Certification in Advanced Cardiovascular Life Support or pediatric Advanced Life Support through a course that follows the American Heart Association guidelines. Pediatric Advanced life Support is required if treating pediatric patients (12 years old or under).
- ☐ Proof of one of the following:
  - Board certification or a candidate for board certification by the American Board of Oral and Maxillofacial Surgery, **Form #2758 required**; or
  - Completion of an accredited fellowship in oral and maxillofacial surgery residency, **Form #2758 required;** or
  - Diplomate or candidate of the American Dental Board of Anesthesiology, **Form #2758 required**; or
  - Successful completion of a Board approved education program, **must meet requirements under Wis. Admin. Code § DE 11.035(2)**. **Form #2758 and documentation are required**.

☐ **CERTIFICATION FOR CLASS II-Enteral:** This permit allows a dentist to provide moderate sedation via enteral route.

- ☐ Completed application (**Form #2759**) and fee.
- ☐ Verification of any permit or credential authorizing anesthesia or sedation held by the dentist.
- ☐ Certification in Advanced Cardiovascular Life Support or pediatric Advanced Life Support through a course that follows the American Heart Association guidelines. Pediatric Advanced life Support is required if treating pediatric patients (12 years old or under).
- ☐ Proof of one of the following:
  - Board certification or a candidate for board certification by the American Board of Oral and Maxillofacial Surgery, **Form #2758 required**; or
  - Completion of an accredited fellowship in oral and maxillofacial surgery residency, **Form #2758 required**; or
  - Diplomate or candidate of the American Dental Board of Anesthesiology, **Form #2758 required**; or
  - Successful completion of a Board approved education program, **must meet requirements under Wis. Admin. Code § DE 11.035(1)**. **Form #2758 and documentation are required**.

☐ **CLASS I PERMIT (issued prior to 9/1/2020)** - **TRANSITION TO CERTIFICATION FOR CLASS II-Enteral:** This permit allows a dentist to provide moderate sedation via enteral route. As of September 1, 2020, a dentist holding a Class I permit shall be granted a Class II-Enteral permit upon evidence of twenty (20) cases providing moderate sedation within the last five (5) years.

- ☐ Completed application (**Form #2759**) and fee.
- ☐ Verification of any permit or credential authorizing anesthesia or sedation held by the dentist.
- ☐ Certification in Advanced Cardiovascular Life Support or pediatric Advanced Life Support through a course that follows the American Heart Association guidelines. Pediatric Advanced life Support is required if treating pediatric patients (12 years old or under).
- ☐ Evidence of twenty (20) cases providing moderate sedation within the last five (5) years, **submit completed Form #2759 Addendum**. (**See last page of this form**.)

I AM OR HAVE BEEN LICENSED AUTHORIZING ANESTHESIA OR SEDATION IN THE FOLLOWING STATE(S). (Include all active and inactive licenses.)

For each credential listed above, you are required to have each state board, jurisdiction, territory of the United States, and/or country submit a letter of verification to the Wisconsin Dentistry Examining Board. The verification letter(s) must state your date of birth, credential number, date of issuance, and a statement regarding disciplinary actions.

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Wisconsin Department of Safety and Professional Services

ANSWER THE FOLLOWING QUESTIONS. (Attach additional sheets if necessary.)

1.	Have you ever had any previous anesthesia or sedation related incident, morbidity, mortality, or any Board investigation or discipline related to the delivery of anesthesia or sedation? **If yes, give details on an attached sheet including the date and location of the incident(s).**	☐ Yes ☐ No
2.	Do you attest that you have the required equipment and medications to meet the Standards of Care for the sedation class level permit for which you are applying per Wis. Admin. Code §§ DE 11.085 and 11.09? **If no, give details on an attached sheet.**	☐ Yes ☐ No
3.	I understand, per Wis. Admin. Code § DE 11.10, that any anesthesia or sedation related mortality which occurs during or as a result of treatment I provide must be reported to the Board within two (2) business days of my notice of such mortality and that any morbidity which may result in permanent physical or mental injury as a result of the administration of anesthesia or sedation must be reported to the Board within thirty (30) days of my notice of the occurrence of any such morbidity. (See **Form #2764**.)	☐ Yes ☐ No

CERTIFICATION OF LEGAL STATUS

I declare under penalty of law that I am (check one):

☐ A citizen or national of the United States, or

☐ A qualified alien or nonimmigrant lawfully present in the United States who is eligible to receive this professional license or credential as defined in the Personal Responsibility and Work Opportunities Reconciliation Act of 1996, as codified in 8 U.S.C. §1601 et. Seq. (PRWORA). For questions concerning PRWORA status, please contact the U.S. Citizenship and Immigration Services in the Department of Homeland Security at 1-800-375-5283 or online at http://www.uscis.gov.

Should my legal status change during the application process or after a credential is granted, I understand that I must report this change to the Wisconsin Department of Safety and Professional Services immediately.

CONTINUING DUTY OF DISCLOSURE

I understand that I have a continuing duty of disclosure during the application process. If information I have provided in this application becomes invalid, incorrect, or outdated, I understand that I am obliged to provide any necessary information to ensure the information on my application remains current, valid, and truthful. I understand that credentialing authorities may view acts of omission as dishonesty and that my duty of disclosure during the application process exists until licensure is granted or denied.

AFFIDAVIT OF APPLICANT

I declare that I am the person referred to on this application and that all answers set forth are each and all strictly true in every respect. I understand that failure to provide requested information, making any materially false statement and/or giving any materially false information in connection with my application for a credential or for renewal or reinstatement of 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. I further understand that if I am issued a credential, or renewal, or reinstatement thereof, failure to comply with the statutes and/or administrative code provisions of the licensing authority will be cause of disciplinary action.

By signing below, I am signifying that I have read the above statements (Certification of Legal Status, Continuing Duty of Disclosure, and Affidavit of Applicant) and understand the obligation I have as an applicant or credential-holder should information I've provided to the Department of Safety and Professional Services change.

Signature: ____________________ Date: __ __ / __ __ / __ __ __ __

Wisconsin Department of Safety and Professional Services

FORM 2759 ADDENDUM: Complete this addendum **ONLY IF** you are a dentist who held a **Class I permit on September 1, 2020**, and are applying for a Class II-Enteral permit by submitting evidence of twenty (20) cases of moderate sedation that you have provided within the last five (5) years.

CLASS II-ENTERAL PRACTICE: Account for all activities and practice utilizing moderate sedation for the last five (5) years prior to September 1, 2020. **All** time and dates must be accounted for. (**Attach additional sheets if necessary.**) DO NOT submit patient records containing personal health information (PHI).

1. **Location**

   Type(s) of Anesthesia

   Frequency (average use per week) **From** (month/year) __ __ / __ __ __ __ **To** (month/year) __ __ / __ __ __ __

   Any Adverse Occurrences? ☐ Yes ☐ No (If yes, provide **Form #2764** for each occurrence.)

2. **Location**

   Type(s) of Anesthesia

   Frequency (average use per week) **From** (month/year) __ __ / __ __ __ __ **To** (month/year) __ __ / __ __ __ __

   Any Adverse Occurrences? ☐ Yes ☐ No (If yes, provide **Form #2764** for each occurrence.)

3. **Location**

   Type(s) of Anesthesia

   Frequency (average use per week) **From** (month/year) __ __ / __ __ __ __ **To** (month/year) __ __ / __ __ __ __

   Any Adverse Occurrences? ☐ Yes ☐ No (If yes, provide **Form #2764** for each occurrence.)

4. **Location**

   Type(s) of Anesthesia

   Frequency (average use per week) **From** (month/year) __ __ / __ __ __ __ **To** (month/year) __ __ / __ __ __ __

   Any Adverse Occurrences? ☐ Yes ☐ No (If yes, provide **Form #2764** for each occurrence.)

5. **Location**

   Type(s) of Anesthesia

   Frequency (average use per week) **From** (month/year) __ __ / __ __ __ __ **To** (month/year) __ __ / __ __ __ __

   Any Adverse Occurrences? ☐ Yes ☐ No (If yes, provide **Form #2764** for each occurrence.)

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DENTISTRY EXAMINING BOARD

ANESTHESIA OR CONSCIOUS SEDATION EDUCATION VERIFICATION FORM

APPLICANT: Complete this section and submit to certifying school in which you completed the education. Form must be returned directly from the school or program to the Department at the above address.

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

Address: (number, street, city, zip code)

Date of Birth: __ __ / __ __ / __ __ __ __

Social Security #: (voluntary-for school's use in locating your records) __ __ __ - __ __ - __ __ __ __

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

I hereby authorize the school named below to provide the Department with the information requested below.

Applicant Signature __________ **Date** __ __ / __ __ / __ __ __ __

SCHOOL/COURSE/PROGRAM PROVIDER/BOARD: Complete for level of sedation (Class III, Class II-Parenteral, or Class II-Enteral) as indicated by the applicant above.) Certify completion for the applicant named above for the appropriate section below and return directly to DSPS: You may faxor email with official cover sheet or letter to: (608) 251-3036 or dspscreddentistry@wisconsin.gov.

AFFIDAVIT FOR CLASS III

Name of School/Board:

Location of School/Provider: (city, state)

I attest to the fact that the above-named applicant (check one box below):

☐ is American Board of Oral and Maxillofacial Surgery certified or is a candidate for certification,

OR

☐ has **completed** an oral and maxillofacial surgery residency program accredited by the American Dental Association Commission on Dental Accreditation or its successor agency,

OR

☐ is a diplomate or candidate of the American Dental Board of Anesthesiology,

OR

☐ is enrolled in a postdoctoral residency dental program in dental anesthesiology accredited by the American Dental Association Commission on Dental Accreditation or its successor agency.

The applicant has completed or will complete board certification or dental anesthesiology residency OR has completed oral and maxillofacial surgery residency: __ __ / __ __ / __ __ __ __

Signature __________ **Date** __ __ / __ __ / __ __ __ __

Title __________

AFFIDAVIT FOR CLASS II-PARENTERAL

Name of School/Provider:

Location of School/Provider: (city, state)

I attest to the fact that the above-named applicant (check one box below):

☐ is American Board of Oral and Maxillofacial Surgery certified or is a candidate for certification,
OR
☐ has **completed** an oral and maxillofacial surgery residency program accredited by the American Dental Association Commission on Dental Accreditation or its successor agency,
OR
☐ is a diplomate or candidate of the American Dental Board of Anesthesiology.

The applicant has completed or will complete board certification or dental anesthesiology residency OR has completed oral and maxillofacial surgery residency:

/ /

Signature Date / /

Title

☐ **OTHER (not listed above): I attest to the fact that the above-named applicant** has completed a minimum of 60-hours of training in administration and management of moderate sedation education and training that meets requirements under Wis. Admin. Code § DE 11.035(2). (ATTACH detailed course content and descriptions.)

The applicant completed training hours on:

/ /

If this course has been previously approved by the Wisconsin Dentistry Examing Board, list approval date:

/ /

Signature **Date** / /

Title

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Wisconsin Department of Safety and Professional Services

AFFIDAVIT FOR CLASS II-ENTERAL

Name of School/Board:

Location of School/Provider: (city, state)

I attest to the fact that the above-named applicant (check one box below):

☐ is American Board of Oral and Maxillofacial Surgery certified or is a candidate for certification,

OR

☐ has **completed** an oral and maxillofacial surgery residency program accredited by the American Dental Association Commission on Dental Accreditation or its successor agency,

OR

☐ is a diplomate or candidate of the American Dental Board of Anesthesiology,

The applicant has completed or will complete board certification or dental anesthesiology residency OR has completed oral and maxillofacial surgery residency:

__/__/____

Signature

Date __/__/____

Title

☐ **OTHER (not listed above): I attest to the fact that the above-named applicant** has completed a minimum of 18-hours of training in administration and management of moderate sedation education and training that meets requirements under Wis. Admin. Code § DE 11.035(1). (ATTACH detailed course content and descriptions.)

The applicant completed training hours on:

__/__/____

If this course has been previously approved by the Wisconsin Dentistry Examing Board, list approval date:

__/__/____

Signature

Date __/__/____

Title

DRAFT

Wisconsin Department of Safety and Professional Services

Mail To: P.O. Box 8935
Madison, WI 53708-8935
FAX #: (608) 251-3036
Phone #: (608) 266-2112

Ship To: 4822 Madison Yards Way
Madison, WI 53705
E-Mail: dsps@wisconsin.gov
Website: http://dsps.wi.gov

DENTISTRY EXAMINING BOARD

PROCEDURE FOR REPORTING ADVERSE OCCURRENCES RELATED TO ANESTHESIA ADMINISTRATION

PER WISCONSIN ADMINISTRATIVE CODE:

DE 11.10: Reporting of adverse occurrences related to anesthesia administration.

- A dentist shall report to the Dentistry Examining Board any anesthesia or sedation related mortality which occurs during or as a result of treatment provided by the dentist within two (2) business days of the dentist's notice of such mortality.
- A dentist shall report any morbidity which may result in permanent physical or mental injury as a result of the administration of anesthesia or sedation by the dentist to the Dentistry Examining Board within thirty (30) days of the notice of the occurrence of any such morbidity.
- The report shall include, at the minimum, responses to all of the following:
    1. A description of the dental procedures;
    2. The names of all participants in the dental procedure and any witnesses to the adverse occurrence;
    3. A description of the preoperative physical condition of the patient;
    4. A list of drugs and dosage administered before and during the dental procedures;
    5. A detailed description of the techniques utilized in the administration of all drugs used during the dental procedure;
    6. A description of the adverse occurrence, including the symptoms of any complications, any treatment given to the patient, and any patient response to the treatment; and
    7. A description of the patient's condition upon termination of any dental procedures undertaken.

Report the occurrence on the Report of Adverse Occurrences Related to Anesthesia Administration (**Form #2764**), obtainable from the Department of Safety and Professional Services at http://dsps.wi.gov. Select "*Professions*" from the main toolbar, then "*Dentist*."

Send (**Form #2764**) to the DSPS office at Wisconsin Dentistry Examining Board, DSPS, P.O. Box 8935, Madison, WI 53708-8935, and a copy should be kept for your records. You may fax to 608-251-3036 or email to dspscreddentistry@wisconsin.gov.

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DENTISTRY EXAMINING BOARD

REPORT OF ADVERSE OCCURRENCES RELATED TO ANESTHESIA ADMINISTRATION

PLEASE TYPE OR PRINT IN INK **(Attach additional sheets if necessary.)**

Name of Dentist:

Last Name	**First Name**	**MI**	**License Number**
			-

Address (street, city, state, zip)	**Daytime Telephone Number**
	- -

Date of Occurrence: / /

Patient's Reaction:

Name(s)/Telephone Numbers of all participants in dental procedure and any witness to adverse occurrence:

Name	Daytime Telephone Number
	- -
	- -
	- -

Type of Dental Procedures performed: (Provide a detailed description.):

Description of the preoperative physical condition of the patient:

Detailed description of techniques utilized in the administration of all drugs used during dental procedure:

Description of the adverse occurrence, including symptoms of any complications, treatment given to patient, and patient response to the treatment:

Description of patient's condition upon termination of any dental procedures undertaken:

Please provide all dental charting relevant to this occurrence.

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Wisconsin Department of Safety and Professional Services

LIST OF DRUGS AND DOSAGES ADMINISTERED BEFORE AND DURING THE DENTAL PROCEDURES

Drugs Administered Before Dental Procedure(s):

	Name of Drug	Dosage Strength and Form	Quantity
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

Drugs Administered During Procedure(s):

	Name of Drug	Dosage Strength and Form	Quantity
11.			
12.			
13.			
14.			
15.			
16.			
17.			
18.			
19.			
20.			

I certify that the foregoing information is correct to the best of my knowledge and belief.

Signature: ______________________ Date: __ __ / __ __ / __ __ __ __

Title: ______________________

Committed to Equal Opportunity in Employment and Licensing

Pre-Credential Education Information

Graduate from a dental school accredited by the American Dental Association Commission on Dental Accreditation.

- ~~o~~ A foreign trained dentist may qualify for a license if he or she submits to the Board evidence satisfactory to the board of having graduated from a foreign dental school and of one of the following: ~~in addition, a foreign trained Dentist must submit the same information required of non-foreign trained Dentists listed in Wis. Admin. Code. § DE 2.01(1)(a) to (d),(f) and (g):~~
  - ~~Having been awarded a DDS of DMD degree from an accredited dental school;~~
  - ~~verification of having received a dental diploma, degree, or certificate from a full time, undergraduate supplemental dental education program of at least two academic years at an accredited dental school. The program must provide didactic and clinical education to the level of a DDS or DMD graduate.~~
  - Verification of having been awarded a DDS or DMD degree from an accredited dental school; or
  - Verification of having received a dental diploma, degree or certificate from a full time, undergraduate supplemental dental education program of at least two academic years at an accredited dental school. The program must provide didactic and clinical education to the level of a DDS or DMD graduate.
- In addition, a foreign trained dentist must submit the same information required of non-foreign trained dentists as listed in Wis. Admin. Code. ~~§ DE 2.01(1)(a) to (d),(f) and (g):~~ ch. DE 2.

Anesthesia and Conscious Sedation

Dentists administering anesthesia or sedation (other than nitrous oxide inhalation or anxiolysis) must obtain a permit from the Board. Once attained, the conscious sedation permit is renewed automatically at the time of license renewal ~~without further education~~. Two (2) hours of continuing education on the topic of sedation and anesthesia must be completed each biennium (Wis. Admin Code § 11.075) and may be included in the thirty (30) credit hours required under Wis. Admin. Code § DE 13.03 (1m).

Airway Management or ACLS must be current to practice conscious sedation.

- Approved Courses To Date

Note to Anesthesia and Conscious Sedation Training Providers

- The permit application includes Form # 2758 for training providers to verify that courses already provided to individuals meet ~~the~~ requirements in Wis. Admin. Code ch. DE 11. Providers/ schools must return verification directly to DSPS~~. You~~ and may fax or email form with ~~facility~~ official fax cover sheet or ~~facility~~ cover letter to: (608) 251-3036 or dspscreddentistry@wisconsin.gov.

Application for Licensure

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Form	Description
512	Application for Dental License
3217	Application for Fee Reduction (If applying for a fee reduction, this form **must** accompany the application for the credential.)
1471	Dentist Certificate of Professional Education (This form must be completed by your school and returned directly to the Department)
2829	Malpractice Suits or Claims Form (if applicable)
3085	Application for Predetermination (Submit ONLY if you have been convicted of any felony, misdemeanor, or other violations of federal, state, or local law, including municipal ordinances, in this state or any other)
2252	Convictions and Pending Charges
3071	Fax Payment Form

Application for Certificate to Administer Anesthesia/Conscious Sedation

Form	Description
2759	Application For Dental Permit to Administer Conscious Sedation
2758	Conscious Sedation Provider School Verification Form (This form is for course providers to verify courses already approved)
2764	Report of Adverse Occurrences Related to Anesthesia Administration
3071	Fax Payment Form

Application for Faculty License

Form	Description
2650	Application For Dental Faculty License
2252	Convictions and Pending Charges
2829	Malpractice Suits or Claims Form (if applicable)
3071	Fax Payment Form

Application for Temporary Permit to Practice Dentistry Without Compensation

Form	Description
2850	Application to Practice Dentistry without Compensation
2759	Application For Dental Permit to Administer Conscious Sedation
2252	Convictions and Pending Charges
2829	Malpractice Suits or Claims Form (if applicable)
3071	Fax Payment Form

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DENTISTRY EXAMINING BOARD

DENTAL HYGIENE LICENSE INFORMATION

AN APPLICATION IS NOT COMPLETE UNTIL ALL OF THE FOLLOWING DOCUMENTS HAVE BEEN RECEIVED:

Applicants who have passed the Central Regional Dental Testing Service examination **or other Board-approved examination in clinical and laboratory demonstrations) taken within the 5-year period immediately preceding application**, must file the following with the Dentistry Examining Board at the above address to complete the requirements for licensure in the State of Wisconsin.

1. **Application Form #511** Please complete a current application.
2. **National Board Score Card** Original score reports must be submitted directly from National Board of Dental Hygiene Examiners. **Both passing and failing scores are required.** Copies sent from applicant, photocopies, online verification, or faxes are not acceptable. You may submit an online request at https://www.ada.org/1635.aspx. The testing service should mail your scores directly to DSPS, Attn: Dentistry Examining Board, P.O. Box 8935, Madison, WI 53708-8935
3. **Licensure Fee** Checks or money orders are to be made payable to the Department of Safety and Professional Services.
4. **Regional Examination Requirements** Original score reports must be submitted directly from the testing agency. **Both passing and failing scores are required**. Copies sent from applicant, photocopies, online verifications, or faxes are not acceptable. Please request the testing agency to mail your scores directly to DSPS, Attn: Dentistry Examining Board, P.O. Box 8935, Madison, WI 53708-8935.

   Effective January 1, 2009:

   The Board accepts the following examinations for Dental Hygienists: CRDTS, WREB, CDCA (formerly NERB), SRTA, ADEX, and CITA.

   - **The Commission on Dental Competency Assessments (CDCA); Formerly Northern Regional Examining Board (NERB)**
   - **Western Regional Examining Board (WREB)**
   - **Central Regional Dental Testing Score (CRDTS)**
5. **Verification of Licensure in Other State(s)** You are required to have each state/country board in which you have ever been licensed submit letters of verification to the Wisconsin Dentistry Examining Board. The letters must indicate your license number, date of issuance, status, and a statement regarding disciplinary actions. These letters will be required in order to complete your application for licensure.
6. **Examination on Wisconsin Law** An applicant shall successfully complete an online examination on Wisconsin Statutes and Rules relating to the practice of dentistry before a license can be issued in Wisconsin. Information for the online examination will be provided after an application for licensure has been received at DSPS.
7. **Certificate of Professional Education (Form #1463)** Have your dental hygiene school complete this form and request them to send directly to the Board office.
8. **Certificate of Proficiency in Cardiopulmonary Resuscitation/AED** Submit a copy of the front and back of a current certificate. This certificate must be signed and dated. See the DHS website at https://www.dhs.wisconsin.gov/ems/licensing/cpr.htm for a listing of approved programs.

TEMPORARY PERMIT CANDIDATES: A temporary license may be granted to an applicant who meets all of the requirements for licensure except the clinical examination. **A person who has taken the clinical exam and failed is not eligible.**

- A person holding a temporary license is required to practice under the supervision of a licensed dentist. Supervision is defined as a person of immediate availability to coordinate, direct, and inspect the practice of the holder of the temporary license either by being on site or available to collaborate through the use of communication technology.
- The temporary license is valid for a period of 3 months or until the holder receives a regular license or notification of failing the clinical exam.

Your application with all supporting documents must be on file 30 days prior to the date on which you wish to be granted permanent licensure.

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DENTISTRY EXAMINING BOARD

APPLICATION FOR DENTAL HYGIENE LICENSE

The Department must deny your application if you are liable for delinquent state taxes, UI contributions, or child support (Wis. Stat. §§ 440.12 and 440.13).

PLEASE TYPE OR PRINT IN INK

☐ Your name, address, telephone number, and electronic address are available to the public. Check box to withhold address, telephone number, and email address from lists of 10 or more credential holders (Wis. Stat. § 440.14).

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

Address (street, city, state, zip)	**Daytime Telephone Number**
	___ - ___ - ____
Mailing Address (if different)	**Date of Birth**
	__ / __ / ____

Social Security Number ___ - __ - ____

Your Social Security Number or Employer Identification Number must be submitted with your application on this form. If you do not have a Social Security Number, you must complete Form #1051. The Department may not disclose the Social Security Number collected except as authorized by law.

Ethnicity/gender status information is optional.

Ethnicity: ☐ White, not of Hispanic origin ☐ American Indian or Alaskan ☐ Hispanic
☐ Black, not of Hispanic origin ☐ Asian or Pacific Islander ☐ Other

Sex: ☐ M ☐ F

Have you ever been licensed in Wisconsin as a Dental Hygienist? ☐ Yes ☐ No If yes, list your credential number:

Email Address

School Name	**School Address** (street, city, state)

Date Degree Conferred	**Degree**	**Specialty**
__ / __ / ____		

APPLICATION FEES: Please check applicable box. Make check payable to DSPS and attach to this application.

☐ **I am seeking a Veteran Fee Waiver** (for Initial Credential Fee only, see page 2 for further information)

☐ **Exam Applicants** (**CRDTS, WREB, CDCA, NERB, SRTA, CITA**)
$ 75.00 Initial Credential Fee
$ 75.00 State Law Exam
$150.00 Total Fee Attached

☐ **Endorsement of a State Board**
$123.00 Initial Credential Fee
$ 75.00 State Law Exam
$198.00 Total Fee Attached

☐ **Temporary Permit Fee** (for applicants who have not taken a clinical exam or who are awaiting clinical exam results)
$ 10.00 Temporary Permit Fee (additional fee, non-refundable)

For Receipting Use Only (16)

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Wisconsin Department of Safety and Professional Services

APPLICATION IS NOT COMPLETE UNTIL ALL OF THE FOLLOWING DOCUMENTS HAVE BEEN RECEIVED:

- ☐ Application (**Form #511**) and appropriate fee
- ☐ Regional Dental Testing Service Score(s) (Original Pass and Fail)
- ☐ National Board Score Card(s) (Original Pass and Fail)
- ☐ Letters from all State Boards where licensed, active and inactive
- ☐ Certificate of Professional Education (**Form #1463**)
- ☐ Current CPR/AED Certificate
- ☐ Wisconsin Statutes and Rules Examination (online examination)
- ☐ Convictions and Pending Charges (**Form #2252**), if applicable
- ☐ Malpractice Suits or Claims (**Form #2829**) and copies of malpractice suit, court documents with allegations and settlement, if applicable
- ☐ Is name on all credentials the same? If not, submit certified copy of marriage certificate, divorce decree, etc.
- ☐ If applying for a temporary permit, **Form #3572** is required

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ARE YOU A VETERAN? If yes, please view the Department website at https://dsps.wi.gov/Pages/Professions/MilitaryLicensureBenefits.aspx for eligibility requirements.

If you qualify, are you requesting a waiver of your initial credentialing fee? ☐ Yes ☐ No

If Yes, provide a copy of your Department of Veterans Affairs voucher code and list your DVA Voucher Code Number: ______

If you qualify, are you requesting equivalency of your Military Training and experience? ☐ Yes ☐ No

If Yes, complete and return the Veteran Request Application Addendum (**Form #2996**). This form must be included with this application.

If you qualify, are you requesting Temporary Spousal Reciprocal License? ☐ Yes ☐ No

If Yes, do not complete this form. You must complete and return the Application for Temporary Spousal Reciprocal License (**Form #2982**).

You may contact the DVA at 1-800-WisVets or www.WISVET.com for assistance in obtaining your DVA Voucher Code and/or documents related to your training.

CONTINUING EDUCATION AND RENEWAL REQUIREMENTS: Please view the Department website at http://dsps.wi.gov and select "Professions," then "Dental Hygienist."

Have you been tested by a Regional Dental Testing Service?

☐ Yes ☐ No

If yes, provide original score card(s) of certification/notification of passing/failing and date and please indicate which examination:

- ☐ The Commission on Dental Competency Assessments (CDCA) Formerly Northern Regional Examining Board (NERB)
- ☐ Western Regional Examining Board (WREB)
- ☐ Central Regional Dental Testing Score (CRDTS)
- ☐ Southern Regional Testing Agency (SRTA)
- ☐ Council of Interstate Testing Agency (CITA)

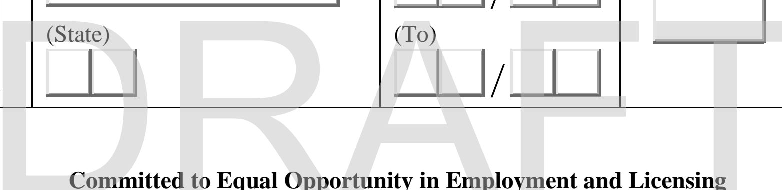
If no, please explain: ______

Have you taken and passed the National Boards?

☐ Yes ☐ No If yes, submit original cards from the National Boards.

PRACTICE: Account for all activities and practice starting from the date of graduation to the present time. Must include professional and nonprofessional activities. All time and dates must be accounted for. (Attach additional sheets, if necessary.)

Employer/Institution/Activity	**Location of Employment** (City/State)	**Dates Employed** (Month/Year)	**# Hours Per Week**	**The Capacity in Which You Are/Were Employed**
	(City) (State)	(From) / (To) /		
	(City) (State)	(From) / (To) /		
	(City) (State)	(From) / (To) /		



Committed to Equal Opportunity in Employment and Licensing

Wisconsin Department of Safety and Professional Services

I AM OR HAVE BEEN LICENSED IN THE FOLLOWING STATE(S). (Include all active and inactive states.)

For each credential listed above, you are required to have each State Board or territory of the United States submit a letter of verification to the Wisconsin Dentistry Examining Board. The verification letter(s) must state your date of birth, credential number, date of issuance, and a statement regarding disciplinary actions.

REGARDING THE STATES YOU LISTED ABOVE: Identify the states in which you were licensed by EXAM.

ANSWER THE FOLLOWING QUESTIONS. (Attach additional sheets if necessary.)

1.	Have you ever surrendered, resigned, canceled, or been denied a professional license or other credential in Wisconsin, or any other jurisdiction? **If yes, give details on an attached sheet, including the name of the profession and the agency.**	☐ Yes ☐ No
2.	Have you ever failed to pass any state board examination, national board examination? **If yes, provide details below: (Original pass/fail cards required.)**	☐ Yes ☐ No
3.	Has any licensing or other credentialing agency ever taken any disciplinary action against you, including but not limited to any warning, reprimand, suspension, probation, limitation, or revocation? **If yes, attach a sheet providing details about the action, including the name of the credentialing agency and date of action.**	☐ Yes ☐ No
4.	Is disciplinary action pending against you in any jurisdiction? **If yes, attach a sheet providing details about pending action, including the name of the agency and status of action.**	☐ Yes ☐ No
5.	Have you ever been convicted of a misdemeanor, felony, or other violation of federal, state, or local law or do you have any felony, misdemeanor or other violation of federal, state, or local law charges pending against you in this state or any other? This includes municipal ordinances resulting only in monetary fines or forfeitures and convictions resulting from a plea of no contest, a guilty plea, or verdict.	☐ Yes ☐ No
6.	If yes to question 5 above, did you apply for a predetermination of the convictions? **If YES, proceed to question 7.** **If NO, submit Convictions and Pending Charges (Form #2252) and supporting documentation.**	☐ Yes ☐ No
7.	If yes to question 6, did you receive a letter indicating the convictions and pending charges did not disqualify you from licensure? **If YES, proceed to question 8.** **If NO, submit Convictions and Pending Charges Form #2252 and supporting documentation.**	☐ Yes ☐ No
8.	If yes to question 7, since the date of the letter indicating you were not disqualified from licensure, have you been convicted of a misdemeanor, felony, or other violation of federal, state, or local law or do you have any felony, misdemeanor or other violation of federal, state, or local law charges pending against you in this state or any other? This includes municipal ordinances resulting only in monetary fines or forfeitures and convictions resulting from a plea of no contest, a guilty plea, or verdict. **If YES, submit Convictions and Pending Charges Form #2252 and supporting documentation for each conviction and pending charge since the date of the letter.** **If NO, submit Convictions and Pending Charges Form #2252 without previously submitted documentation.**	☐ Yes ☐ No
9.	Are you incarcerated, on probation, or on parole for any conviction? **If applicable, attach a sheet providing details including the terms of incarceration and a copy of a report from your probation or parole officer.**	☐ Yes ☐ No
10.	Have any suits or claims ever been filed against you as a result of professional services? **If yes, Malpractice Suits or Claims (Form #2829).**	☐ Yes ☐ No
11.	Are you registered or licensed in any other profession(s)? **If yes, state what profession(s) and in what state(s):**	☐ Yes ☐ No
12.	Have you ever been credentialed under any other name(s)? **If yes, state name(s) credentialed under:**	☐ Yes ☐ No

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Wisconsin Department of Safety and Professional Services

For the purposes of these questions, the following phrases or words have the following meanings:

"Ability to practice dentistry" is to be construed to include all of the following:
1. The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned dentistry judgments and to learn and keep abreast of dentistry developments; and
2. The ability to communicate those judgments and dental information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
3. The physical capability to perform medical tasks such as physical examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.

"Medical Condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to, orthopedic, visual, speech and hearing impairments, Cerebral Palsy, epilepsy, Muscular Dystrophy, Multiple Sclerosis, cancer, heart disease, Diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction and alcoholism.

"Chemical Substances" is to be construed to include alcohol, drugs, or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

"Currently" does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather, it means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, or **within the past two years.**

"Illegal use of Controlled Dangerous Substances" means the use of controlled dangerous substances obtained illegally (e.g. heroin or cocaine) as well as the use of controlled dangerous substances, which are not obtained pursuant to a valid prescription, or not taken in accordance with the directions of a licensed health care practitioner.

ANSWER THE FOLLOWING QUESTIONS. (Attach additional sheets if necessary.)

13.	Do you have a medical condition, which in any way impairs or limits your ability to practice dentistry with reasonable skill and safety? If no, you may skip questions 14 and 15. **If yes, please explain.**	☐ Yes ☐ No
14.	If yes to question 13, are the limitations or impairments caused by your medical condition reduced or ameliorated because you receive ongoing treatment (with or without medications) or participate in a monitoring program? **If yes, please explain**.	☐ Yes ☐ No
15.	If yes to question 13, are the limitations or impairments caused by your medical condition reduced, or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice? **If yes, please explain.**	☐ Yes ☐ No
16.	Does your use of chemical substance(s) in any way impair, or limit your ability to practice dentistry with reasonable skill and safety? **If yes, please explain.**	☐ Yes ☐ No
17.	Have you ever been diagnosed as having, or have you ever been treated for pedophilia, exhibitionism, or voyeurism? **If yes, please explain.**	☐ Yes ☐ No
18.	Are you currently engaged in the illegal use of controlled dangerous substances?	☐ Yes ☐ No
19.	If yes to question 18, are you currently participating in a supervised rehabilitation program or professional assistance program, which monitors you in order to assure that you are not engaging in the illegal use of controlled dangerous substances? **If yes, please explain.**	☐ Yes ☐ No

CERTIFICATION OF LEGAL STATUS

I declare under penalty of law that I am (check one):

☐ A citizen or national of the United States, or

☐ A qualified alien or nonimmigrant lawfully present in the United States who is eligible to receive this professional license or credential as defined in the Personal Responsibility and Work Opportunities Reconciliation Act of 1996, as codified in 8 U.S.C. §1601 et. Seq. (PRWORA). For questions concerning PRWORA status, please contact the U.S. Citizenship and Immigration Services in the Department of Homeland Security at 1-800-375-5283 or online at http://www.uscis.gov.

Should my legal status change during the application process or after a credential is granted, I understand that I must report this change to the Wisconsin Department of Safety and Professional Services immediately.

CONTINUING DUTY OF DISCLOSURE

I understand that I have a continuing duty of disclosure during the application process. If information I have provided in this application becomes invalid, incorrect, or outdated, I understand that I am obliged to provide any necessary information to ensure the information on my application remains current, valid, and truthful. I understand that credentialing authorities may view acts of omission as dishonesty and that my duty of disclosure during the application process exists until licensure is granted or denied.

AFFIDAVIT OF APPLICANT

I declare that I am the person referred to on this application and that all answers set forth are each and all strictly true in every respect. I understand that failure to provide requested information, making any materially false statement and/or giving any materially false information in connection with my application for a credential or for renewal or reinstatement of 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. I further understand that if I am issued a credential, or renewal, or reinstatement thereof, failure to comply with the statutes and/or administrative code provisions of the licensing authority will be cause of disciplinary action.

By signing below, I am signifying that I have read the above statements (Certification of Legal Status, Continuing Duty of Disclosure, and Affidavit of Applicant) and understand the obligation I have as an applicant or credential-holder should information I've provided to the Department of Safety and Professional Services change.

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Signature: ______________________ Date: __ __ / __ __ / __ __ __ __

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DENTISTRY EXAMINING BOARD

REQUEST FOR TEMPORARY LICENSE FOR DENTIST OR DENTAL HYGIENIST

- A temporary license may be granted to an applicant who meets all of the requirements for licensure except the clinical examination. A person who has taken the clinical exam and failed is not eligible.
- A person holding a temporary license is required to practice under the supervision of a licensed dentist. Supervision is defined as a person of immediate availability to coordinate, direct, and inspect the practice of the holder of the temporary license either by being on site or available to collaborate through the use of communication technology.
- The temporary license is valid for a period of three (3) months or until the holder receives a regular license or notification of failing the clinical exam.

Type of license applying for: ☐ Dentist ☐ Dental Hygienist

NAME OF APPLICANT (Please print): ______________________________

Applicant, please check one and forward this form to your supervisor:

☐ I plan to take the next clinical examination for dentist or dental hygienist and wish to begin practicing prior to the date of examination.

☐ I have taken the clinical examination, am awaiting results, and wish to begin practicing prior to the next scheduled board meeting for a permanent license.

AFFIDAVIT OF SUPERVISING DENTIST: **Supervisor may fax or email form directly to DSPS, facility with cover sheet or cover letter, to (608) 251-3036 or DSPSCredDentistry@wisconsin.gov.**

I request that a temporary license to practice as a dentist or dental hygienist in the State of Wisconsin be issued to ______________________________. (Name)

I am aware that this temporary license will expire when the applicant is notified he/she failed the clinical examination, or on the date the board grants or denies an applicant a permanent license.

____
Signature and Title

____
Print Name and Wisconsin Dentist Credential #

(______) ______________________________
Phone Number

____
Facility Name

____
Street Address

____
City and State Zip Code

____
Date

#3572 (Rev. 8/20)
Wis. Stat. ch. 447

Committed to Equal Opportunity in Employment and Licensing

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DENTISTRY EXAMINING BOARD

DENTAL HYGIENE CERTIFICATE OF PROFESSIONAL EDUCATION

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, zip code)

Date of Birth: __/__/____

Social Security #: (voluntary-for school's use in locating your records) ___-__-____

I hereby authorize the school named below to provide the Department with the information requested below.

Applicant Signature **Date** __/__/____

SCHOOL/COURSE PROVIDER: Certify completion after the applicant named above has actually graduated and return directly to DSPS. school may fax or email with school cover sheet or cover letter to: (608) 251-3036 or dspscreddentistry@wisconsin.gov.

Name of School/Institution:

Location of School/Institution: (city, state)

Type of Degree Awarded:

Major:

Date of Completion: __/__/____ (anticipated dates of graduation will not be accepted)

Signature of Dean or Department Head **Date** __/__/____

Title

DRAFT

Wisconsin Department of Safety and Professional Services

Mail To: P.O. Box 8935
Madison, WI 53708-8935
FAX #: (608) 251-3036
Phone #: (608) 266-2112

Ship To: 4822 Madison Yards Way
Madison, WI 53705
E-Mail: dsps@wisconsin.gov
Website: http://dsps.wi.gov

DENTISTRY EXAMINING BOARD

APPLICATION FOR DENTAL HYGIENE CERTIFICATE TO ADMINISTER LOCAL ANESTHESIA

The Department must deny your application if you are liable for delinquent state taxes, UI contributions, or child support (Wis. Stat. §§ 440.12 and 440.13).

PLEASE TYPE OR PRINT IN INK

☐ Your name, address, telephone number, and email address are available to the public. Check box to withhold this information from lists of 10 or more credential holders (Wis. Stat. § 440.14).

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

Address (street, city, state, zip)

Daytime Telephone Number ___ - ___ - ____

Mailing Address (if different)

Date of Birth __ / __ / ____

Social Security Number ___ - __ - ____

Your Social Security Number or Employer Identification Number must be submitted with your application on this form. If you do not have a Social Security Number, you must complete Form #1051. The Department may not disclose the Social Security Number collected except as authorized by law.

Have you ever been licensed in Wisconsin as a Dental Hygienist? ☐ **Yes** ☐ **No**

If yes, list WI License Number: ________ -16

Email Address

School Name

School Address (street, city, state)

Course Title

Date Course Completed __ / __ / ____

APPLICATION IS NOT COMPLETE UNTIL THE FOLLOWING DOCUMENTS HAVE BEEN RECEIVED:

- A copy of current CPR/AED Certificate (If submitting a wallet card, provide **front and back**.)
- A Local Anesthesia Certificate of Completion from an Accredited Dental or Dental Hygiene School, (**Form #2457**).
- Certification of Inferior Alveolar Injection (**Form #2458**) - only required for dental hygienists who are employed and taking a local anesthesia program as continuing education outside of the initial accredited dental hygiene program.

Please continue to and fully complete page 2.

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Wisconsin Department of Safety and Professional Services

CERTIFICATION OF LEGAL STATUS:

I declare under penalty of law that I am (check one):

- ☐ A citizen or national of the United States, or
- ☐ A qualified alien or nonimmigrant lawfully present in the United States who is eligible to receive this professional license or credential as defined in the Personal Responsibility and Work Opportunities Reconciliation Act of 1996, as codified in 8 U.S.C. §1601 et. Seq. (PRWORA). For questions concerning PRWORA status, please contact the U.S. Citizenship and Immigration Services in the Department of Homeland Security at 1-800-375-5283 or online at http://www.uscis.gov.

Should my legal status change during the application process or after a credential is granted, I understand that I must report this change to the Wisconsin Department of Safety and Professional Services immediately.

CONTINUING DUTY OF DISCLOSURE:

I understand that I have a continuing duty of disclosure during the application process. If information I have provided in this application becomes invalid, incorrect or outdated, I understand that I am obliged to provide any necessary information to ensure the information on my application remains current, valid, and truthful. I understand that credentialing authorities may view acts of omission as dishonesty and that my duty of disclosure during the application process exists until licensure is granted or denied.

AFFIDAVIT OF APPLICANT:

I declare that I am the person referred to on this application and that all answers set forth are each and all strictly true in every respect. I understand that failure to provide requested information, making any materially false statement and/or giving any materially false information in connection with my application for a credential or for renewal or reinstatement of 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. I further understand that if I am issued a credential, or renewal, or reinstatement thereof, failure to comply with the statutes and/or administrative code provisions of the licensing authority will be cause of disciplinary action.

By signing below, I am signifying that I have read the above statements (Certification of Legal Status, Continuing Duty of Disclosure, and Affidavit of Applicant) and understand the obligation I have as an applicant or credential-holder should information I've provided to the Department of Safety and Professional Services change.

Signature: ______________________ Date: __ __ / __ __ / __ __ __ __

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DENTISTRY EXAMINING BOARD

LOCAL ANESTHESIA CERTIFICATE OF COMPLETION

APPLICANT: Complete this section and submit to certifying school in which you completed the education 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, zip code)

Date of Birth: __ __ / __ __ / __ __ __ __

Social Security #: (voluntary-for school's use in locating your records) __ __ __ - __ __ - __ __ __ __

I hereby authorize the school named below to provide the Department with the information requested below.

Applicant Signature | **Date** __ __ / __ __ / __ __ __ __

SCHOOL/INSTITUTION: Certify completion for the applicant named above and return directly to DSPS. Facility may fax or email with facility cover sheet or cover letter to: (608) 251-3036 or dspscreddentistry@wisconsin.gov.

Name of School/Institution:

Location of School/Institution: (city, state)

Name of Course:

Date of Course Completion: __ __ / __ __ / __ __ __ __ (anticipated dates of graduation will not be accepted)

Has applicant completed an inferior alveolar injection on a non-classmate patient as part of the coursework?
(If yes, check box) ☐

The completion of this form by the instructor certifies that the course completed is in compliance with Wis. Admin. Code § DE 7.

Signature of Dean or Department Head | **Date** __ __ / __ __ / __ __ __ __

Title

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DENTISTRY EXAMINING BOARD

CERTIFICATE OF INFERIOR ALVEOLAR INJECTION

Pursuant to Wis. Admin. Code § DE 7(3), 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.

SUPERVISING DENTIST: Certify completion for the applicant named below and return directly to DSPS. The supervising dentist may fax or email the completed form with a facility cover sheet or a cover letter to (608) 251-3036 or dspscreddentistry@wisconsin.gov.

Applicant:

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

Name of Practice: ______

Street Address: (street, city, state and zip) ______

Daytime Phone Number: ___ - ___ - ____

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.

______ __/__/____

Signature of Supervising Dentist **Date**

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DENTISTRY EXAMINING BOARD

APPLICATION FOR DENTAL HYGIENE CERTIFICATE TO ADMINISTER NITROUS OXIDE

The Department must deny your application if you are liable for delinquent state taxes, UI contributions, or child support (Wis. Stat. §§ 440.12 and 440.13).

PLEASE TYPE OR PRINT IN INK ☐ Your name, address, telephone number, and email address are available to the public. Check box to withhold this information from lists of 10 or more credential holders (Wis. Stat. § 440.14).

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

Address (street, city, state, zip)

Daytime Telephone Number ___ - ___ - ____

Mailing Address (if different)

Date of Birth __ / __ / ____

Social Security Number ___ - __ - ____

Your Social Security Number or Employer Identification Number must be submitted with your application on this form. If you do not have a Social Security Number, you must complete Form #1051. The Department may not disclose the Social Security Number collected except as authorized by law.

Email Address

Have you ever been licensed in Wisconsin as a Dental Hygienist? ☐ **Yes** ☐ **No**

If yes, list WI License Number: ____ -16

School Name

School Address (street, city, state)

Course Title

Date Course Completed __ / __ / ____

APPLICATION IS NOT COMPLETE UNTIL THE FOLLOWING DOCUMENTS HAVE BEEN RECEIVED:

- A Nitrous Oxide Certificate of Completion from an Accredited Dental or Dental Hygiene School **(Form #3164)**.

Please continue to and fully complete page 2.

DRAFT

Wisconsin Department of Safety and Professional Services

CERTIFICATION OF LEGAL STATUS:

I declare under penalty of law that I am (check one):

- ☐ A citizen or national of the United States, or
- ☐ A qualified alien or nonimmigrant lawfully present in the United States who is eligible to receive this professional license or credential as defined in the Personal Responsibility and Work Opportunities Reconciliation Act of 1996, as codified in 8 U.S.C. §1601 et. Seq. (PRWORA). For questions concerning PRWORA status, please contact the U.S. Citizenship and Immigration Services in the Department of Homeland Security at 1-800-375-5283 or online at http://www.uscis.gov.

Should my legal status change during the application process or after a credential is granted, I understand that I must report this change to the Wisconsin Department of Safety and Professional Services immediately.

CONTINUING DUTY OF DISCLOSURE

I understand that I have a continuing duty of disclosure during the application process. If information I have provided in this application becomes invalid, incorrect or outdated, I understand that I am obliged to provide any necessary information to ensure the information on my application remains current, valid, and truthful. I understand that credentialing authorities may view acts of omission as dishonesty and that my duty of disclosure during the application process exists until licensure is granted or denied.

AFFIDAVIT OF APPLICANT

I declare that I am the person referred to on this application and that all answers set forth are each and all strictly true in every respect. I understand that failure to provide requested information, making any materially false statement and/or giving any materially false information in connection with my application for a credential or for renewal or reinstatement of 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. I further understand that if I am issued a credential, or renewal, or reinstatement thereof, failure to comply with the statutes and/or administrative code provisions of the licensing authority will be cause of disciplinary action.

By signing below, I am signifying that I have read the above statements (Certification of Legal Status, Continuing Duty of Disclosure, and Affidavit of Applicant) and understand the obligation I have as an applicant or credential-holder should information I've provided to the Department of Safety and Professional Services change.

Signature: ________________ Date: __ __ / __ __ / __ __ __ __

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DENTISTRY EXAMINING BOARD

NITROUS OXIDE CERTIFICATE OF COMPLETION

APPLICANT: Complete this section and submit to the school/course provider in which you completed the education. Form must be returned directly from the school/course provider to the Department.

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

Address: (number, street, city, zip code)

Date of Birth: ___ / ___ / ____

Social Security #: (voluntary-for school/course provider's use in locating your records) ___ - ___ - ____

I hereby authorize the school/course provider named below to provide the Department with the information requested below.

Applicant Signature **Date** ___ / ___ / ____

SCHOOL/COURSE PROVIDER: Certify completion below and return directly to DSPS. You may fax or email with facility cover sheet or cover letter to (608) 251-3036 or dspscreddentistry@wisconsin.gov.

Name of School/Course Provider:

Location of School/Course Provider:
(city, state)

Date of Completion: ___ / ___ / ____

The completion of this form by the instructor certifies that the certification program completed is in compliance with Wis. Admin. Code ch. DE 15.

Signature **Date** ___ / ___ / ____

Title

DRAFT

FORMS CURRENTLY ON WEBSITE: September 2, 2020

Dentist – WEBPAGE

512 Application for Dental License

Faculty

2650 Application For Dental Faculty License

Sedation

2759 Application For Dental Permit to Administer Conscious Sedation

2758 Conscious Sedation Provider School Verification Form (This form is for course providers to verify courses already approved)

2764 Report of Adverse Occurrences Related to Anesthesia Administration

Without compensation

2850 Application to Practice Dentistry without Compensation

Dental Hygienist - WEBPAGE

511 Application For Dental Hygiene License

1463 Dental Hygiene Certificate of Professional Education

Nitrous / Anesthesia

2455 Application For Dental Hygiene Certificate to Administer Local Anesthesia

2458 Certification of Inferior Alveolar Injection

2457 Local Anesthesia Certificate of Completion

3163 Application for Dental Hygiene to Administer Nitrous Oxide

3164 Nitrous Oxide Certificate of Completion

Without compensation

2853 Application for Temporary Permit to Practice Dental Hygiene Without Compensation