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

ANESTHESIA OR CONSCIOUS SEDATION EDUCATION VERIFICATION FORM

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

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

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

Address (number, street, city, zip code)

Date of Birth (__/__/____)

Social Security Number (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 **(Print and Sign Form)** | **Date** (__/__/____)

Certifying Body (school, Board, program, or course provider): Complete for one level of sedation (Class II-Enteral, Class II-Parenteral, or Class III) as indicated by the applicant above.) Certify applicant education for the appropriate class level and return directly to DSPS. Certifying body may fax or email with official cover sheet or letter to (608) 251-3036 or dspscreddentistry@wisconsin.gov.

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 (complete one option and sign and date below):

☐ has completed a minimum of 18-hours of training in administration and management of moderate sedation education and training that includes 20 clinical cases (which may include group observation cases) and meets requirements under Wis. Admin. Code § DE 11.035(1). (ATTACH detailed course content and descriptions.)	**Completion Date** (__/__/____)
☐ has completed an oral and maxillofacial surgery residency program accredited by the American Dental Association Commission on Dental Accreditation or its successor agency.	**Completion Date** (__/__/____)
☐ is American Board of Oral and Maxillofacial Surgery certified or is a candidate for certification. (Check appropriate box to the right.)	☐ **Certified** or ☐ **Candidate for Certification**
☐ is a diplomate or candidate of the American Dental Board of Anesthesiology. (Check appropriate box to the right.)	☐ **Diplomate** or ☐ **Candidate**

Signature **(Print and Sign Form)** | **Date** (__/__/____)

Title

Wisconsin Department of Safety and Professional Services

Certifying Body (school, Board, program, or course provider): Complete for one level of sedation (Class II-Enteral, Class II-Parenteral, or Class III) as indicated by the applicant at the top of page 1.) Certify applicant education for the appropriate class level and return directly to DSPS. Certifying body may fax or email with official cover sheet or letter to (608) 251-3036 or dspscreddentistry@wisconsin.gov.

AFFIDAVIT FOR CLASS II-PARENTERAL

Name of School/Board:

Location of School/Provider: (city, state)

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

☐ has completed a minimum of 60-hours of training in administration and management of moderate sedation education and training that includes 20 clinical cases that includes 20 clinical individually managed cases and meets requirements under Wis. Admin. Code § DE 11.035(2). (ATTACH detailed course content and descriptions.)	**Completion Date** __/__/____
☐ has completed an oral and maxillofacial surgery residency program accredited by the American Dental Association Commission on Dental Accreditation or its successor agency.	**Completion Date** __/__/____
☐ is American Board of Oral and Maxillofacial Surgery certified or is a candidate for certification. (Check appropriate box to the right.)	☐ **Certified** or ☐ **Candidate for Certification**
☐ is a diplomate or candidate of the American Dental Board of Anesthesiology. (Check appropriate box to the right.)	☐ **Diplomate** or ☐ **Candidate**

Signature (Print and Sign Form) **Date** __/__/____

Title

AFFIDAVIT FOR CLASS III

Name of School/Board:

Location of School/Provider: (city, state)

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

☐ postdoctoral residency dental program in dental anesthesiology accredited by the American Dental Association Commission on Dental Accreditation or its successor agency.	**Completion Date** __/__/____
☐ has completed an oral and maxillofacial surgery residency program accredited by the American Dental Association Commission on Dental Accreditation or its successor agency.	**Completion Date** __/__/____
☐ is American Board of Oral and Maxillofacial Surgery certified or is a candidate for certification. (Check appropriate box to the right.)	☐ **Certified** or ☐ **Candidate for Certification**
☐ is a diplomate or candidate of the American Dental Board of Anesthesiology. (Check appropriate box to the right.)	☐ **Diplomate** or ☐ **Candidate**

Signature (Print and Sign Form) **Date** __/__/____

Title