Wisconsin Department of Safety and Professional Services

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

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

DENTISTRY EXAMINING BOARD

DENTAL THERAPIST PROFESSIONAL EDUCATION VERIFICATION

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

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

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

Date of Birth	**Social Security Number** (voluntary-for use by school to locate your records)	**Date of Graduation** (Anticipated dates of graduation will not be accepted.)
__ __ / __ __ / __ __ __ __	__ __ __ - __ __ - __ __ __ __	__ __ / __ __ / __ __ __ __

Date you submitted your application to the Department (DSPS):	__ __ / __ __ / __ __ __ __

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

Applicant Signature (Provide a digital signature or print and sign form.)	**Date**
	__ __ / __ __ / __ __ __ __

PROGRAM/SCHOOL PROVIDER: Complete this section for the above-named applicant and email directly to the Department, DSPSCREDDentistry@wisconsin.gov. **(Type "Dental Therapist' in the subject line.)**

Name of Program/School				
Location of Program/School	**City**		**State**	
Type of Degree Awarded				
Name of Program or Major				
Applicant Date of Graduation	__ __ / __ __ / __ __ __ __	(Anticipated dates of graduation will not be accepted.)		

Program/school provider section continued Page 2.

Wisconsin Department of Safety and Professional Services

Dental Therapist Program Education License Requirements: Check one of the following (Wis. Stat. § 447.04(1m)(c)):

☐	1.	The dental therapy education program was accredited at the time of the applicant's graduation.			
		Date of accreditation	__ __ / __ __ / __ __ __ __	Accrediting body	
☐	2.	The dental therapy education program was not accredited at the time of graduation but satisfies both A and B below. A. The program was approved by the Minnesota Board of Dentistry on or before February 2, 2024, and B. The program was accredited as of the date the applicant submitted a license application.			
		Date of accreditation	__ __ / __ __ / __ __ __ __	Accrediting body	
☐	3.	Dental therapy education program was located in this state. The program received initial accreditation at the time of application graduation but was not fully accredited at that time.			
		Date of accreditation	__ __ / __ __ / __ __ __ __	Accrediting body	

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

Signature of Dean or Department/Program Head (Provide a digital signature or print and sign form.)	**Date**
	__ __ / __ __ / __ __ __ __

Printed Name	**Phone Number**
Title	**Email address**