Wisconsin Department of Safety and Professional Services

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DENTISTRY EXAMINING BOARD

EXPANDED FUNCTION DENTAL AUXILIARY EDUCATION AND TRAINING VERIFICATION

APPLICANT INFORMATION: Complete this section and submit it to the certifying educational program for completion. Form must be returned directly from the certifying educational program to the Department. (Failure to follow form instructions will result in processing delays.) (Note: The provision of your Social Security Number is optional and voluntary for school use in locating your records.)

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

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

Date of Birth	**Social Security Number**	**Application Number**
____/ ____/ __________	______ - _____ - __________	

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

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

DENTAL AUXILIARY EDUCATION PROVIDER: Complete this section for the above-named applicant and return it directly to the Department using the LicensE Third-Party* Upload Portal at license.wi.gov. You will need the application number shown above. (*For form completion purposes, the term "Third-Party" refers to any non-applicant or non-DSPS individual or entity submitting required documentation in support of a credential application.)

Name of School/Institution				
Location of School (City, State)	**City**		**State**	

Per Wis. Stat. § 447.035(3)(b)1, was the applicant required to demonstrate completion of **ONE** of the following **before** enrollment in this program: **(1)** at least 1,000 hours practicing as a dental assistant **if** holding a certified dental assistant credential issued by the Dental Assisting National Board, Inc. (DANB), or its successor; **OR, (2)** at least 2,000 hours practicing as a dental assistant, as verified by the supervising licensed dentist? ☐ **Yes** ☐ **No**

Date Applicant Enrolled in Program	___/ ___/ _______	**Date of Program Completion**	___/ ___/ _______
Number of hours required for program completion?		**(Anticipated dates of completion will not be accepted.)**	
Type of Degree Awarded		**Major**	

Was program accredited at time of applicant completion? ☐ **Yes** ☐ **No** **If yes, list accrediting body below:**

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

Signature of Dean or Department Head (Provide digital signature or print and sign form.)	**Date**
	___/ ___/ _______
Printed Name	**Phone Number**
	______ - _____ - ________
Title	