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
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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 program for completion. Form must be returned directly from the certifying program to the Department.

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

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

Date of Birth	**Social Security Number** (voluntary, for school use to locate your records)	**Application Number**
____/ ____/ _____	__ __ – __ __ __ – __ __ __ __	**PAR-**

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**
	____/ ____ / _____

EXPANDED FUNCTION DENTAL AUXILIARY PROGRAM 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/Program			
School Location	**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.)

Indicate the EFDA training and practice areas that are included in the program. (Check all that apply.)

☐	Placement and finishing of restoration material after the dentist prepares a tooth for restoration	☐	Packing cord
☐	Application of sealants	☐	Removal of cement from crowns
☐	Coronal polishing	☐	Adjustment of dentures and other removable oral appliances
☐	Impressions	☐	Removal of sutures and dressings
☐	Temporizations	☐	Application of topical fluoride, fluoride varnish, or similar dental topical agent

Program provider completion continued next page.

Wisconsin Department of Safety and Professional Services

Type of Degree or Certificate Awarded	

Was the dental auxiliary education program American Dental Association Commission on Dental Education (CODA) accredited at the time of applicant's completion? ☐ Yes ☐ No **If no, explain how you meet the education requirements:**

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.

Dean or Department, School, or Program Head Signature (Provide digital signature or print and sign form.)	**Date**
	___/ ____ / _____
Printed Name	**Phone Number** (with area code)
Title	