



**LICENSURE FORMS COMMITTEE
DENTISTRY EXAMINING BOARD
Room N208, 4822 Madison Yards Way, 2nd Floor, Madison
Contact: Christian Albouras, (608) 266-2112
March 4, 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

10:00 A.M.

OR IMMEDIATELY FOLLOWING THE DENTISTRY EXAMINING BOARD MEETING

OPEN SESSION – CALL TO ORDER – ROLL CALL

A. Adoption of Agenda (1)

B. Approval of Minutes of January 8, 2020 (2)

C. Administrative Matters

- 1) Department, Staff and Board Updates

D. Review of Initial Applications and Renewal Forms – Discussion and Consideration (3-61)

- 1) Application for Dental License
- 2) Application for Dental Faculty License
- 3) Practicing without compensation (Dental and Hygiene)
- 4) Hygiene/Local Anesthesia/Nitrous
- 5) Anesthesia

E. Next Steps

F. Public Comments

ADJOURNMENT

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.

**LICENSURE FORMS COMMITTEE
DENTISTRY EXAMINING BOARD
MEETING MINUTES
JANUARY 8, 2020**

PRESENT: Shaheda Govani, DDS; Wendy Pietz, DDS

EXCUSED: Lisa Bahr, RDH

STAFF: Debra Sybell, 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 11:05 a.m. A quorum was confirmed with two (2) board members present.

ADOPTION OF AGENDA

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

ADOPTION OF MINUTES OF NOVEMBER 6, 2019

MOTION: Wendy Pietz moved, seconded by Shaheda Govani, to adopt the Minutes of November 6, 2019 as published. Motion carried unanimously.

ADJOURNMENT

MOTION: Wendy Pietz, seconded by Shaheda Govani, to adjourn the meeting. Motion carried unanimously.

The meeting adjourned at 11:59 a.m.

Form Order for Dentistry Examining Board Forms Committee March 4, 2020 Meeting

Application for Dental License (512) (with comments)

Application For Dental Faculty License (2650) (with comments)

NEW FORM – Faculty Dentist Certification of Offer of Employment (associated with Form 2650)

Application For Dental Permit to Administer Conscious Sedation (Form 2759)

Conscious Sedation Provider School Verification Form (Form 2758)

Report of Adverse Occurrences Related to Anesthesia Administration (Form 2764)

Application to Practice Dentistry without Compensation (Form 2850)

(DH) Application For Dental Hygiene License (Form 511)

(DH) Application For Dental Hygiene Certificate to Administer Local Anesthesia (Form 2455)

(DH) Certification of Inferior Alveolar Injection (Form 2458)

(DH) Local Anesthesia Certificate of Completion (Form 2457)

(DH) Application for Dental Hygiene to Administer Nitrous Oxide (Form 3163)

(DH) Nitrous Oxide Certificate of Completion (Form 3164)

(DH) Application for Temporary Permit to Practice Dental Hygiene Without Compensation (2853)

Application for Dental License (512) (with comments)

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 at the above address to complete the requirements for licensure in the State of Wisconsin.

- 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.
- National Board Score Card(s)** Original score card(s) must be submitted directly from National Board of Dental Examiners. **Both passing and failing scores are required.** Copies sent from applicant, photocopies, online verification, or faxes are not acceptable. Go to ADA website: <http://www.ada.org/dentpin>, to request your results be electronically sent to WI.
- Regional Examination Requirements** Original score card(s) 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 mail your scores directly to DSPS at the above address or directly to DSPSredDentistry@wisconsin.gov.
- 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 request them to send it directly to DSPS at the above address.
- 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.
- 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.
- 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 DHS website: https://www.dhs.wisconsin.gov/ems/licensing_cpr.htm for a listing of approved programs.
- National Practitioner Data Bank** Go to <http://www.npdb-hipdb.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 report you downloaded with their link. Please forward the email and the attached report directly to DSPSredDentistry@wisconsin.gov. Or, send the original report with the envelope by mail. Please allow 7-10 business days for processing once received here in the Department. Further questions regarding this process may be directed to the Data Bank Help Line at 1-800-767-6732.
- 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 degree, etc.

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

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\(1\)\(a\)\(b\) and \(e\) to \(i\)](#).

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:
 - Verification of having been awarded a DDS or 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 (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\(1\)\(a\) to \(d\), \(f\), \(g\) and \(1m\)\(c\)](#). 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 of non-foreign-trained dentists as listed in [Wis. Admin. Code, §. DE 2.04\(1\)\(b\) and \(e\) to \(i\)](#).

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

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

ADDITIONAL INFORMATION

PLEASE NOTE OTHER APPLICATION TYPES AVAILABLE ON THE DSPS DENTIST WEBPAGE:
<https://dsps.wi.gov/Pages/Professions/Dentist/Default.aspx>.

- [Form 2759, Application for Dental Permit to Administer 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.)

This page contains no comments

Wisconsin Department of Safety and Professional Services

IMPORTANT NOTE: YOUR APPLICATION IS NOT COMPLETE UNTIL ALL OF THE DOCUMENTS LISTED ON PAGE i OF THIS FORM (#512) HAVE BEEN RECEIVED.

Author: guilitaxv Subject: Sticky Note Date: 2/2/2020 1:09:38 PM
 "important note" added since requirement listing was removed from this section of the application. (Sometimes applicants do not print out the information pages, so this reference was added as a prompt)

ARE YOU A VETERAN? If yes, please view the Department website at <https://dps.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.

Author: guilitaxv Subject: Sticky Note Date: 2/2/2020 1:10:53 PM
 Veterans section moved back into the application as it collects the VA code.

CONTINUING EDUCATION AND RENEWAL REQUIREMENTS: Please view the Department website at <http://dps.wi.gov> and select "Professions" and "Dentist."

Have you been tested by a Regional Dental Testing Service? Yes No If yes, submit original score card(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 cards(s) from the National Boards. (See page i for submission instructions.)

I AM OR HAVE BEEN LICENSED IN THE FOLLOWING STATE(S)/COUNTRIES: (include all active and inactive states/countries)

For each credential listed above, you are required to have each State Board or territory of the United States 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.

Wisconsin Department of Safety and Professional Services

ANSWER THE FOLLOWING QUESTIONS (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.	<input type="checkbox"/> Yes <input type="checkbox"/> No
2.	Have you ever failed to pass any state board examination or national board examination? If yes, provide details below: (Original pass/fail cards required.) <input style="width: 100%;" type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> 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.	<input type="checkbox"/> Yes <input type="checkbox"/> 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.	<input type="checkbox"/> Yes <input type="checkbox"/> 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).	<input type="checkbox"/> Yes <input type="checkbox"/> 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.	<input type="checkbox"/> Yes <input type="checkbox"/> 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).	<input type="checkbox"/> Yes <input type="checkbox"/> 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 cards required.)	<input type="checkbox"/> Yes <input type="checkbox"/> No
9.	Are you registered or licensed in any other profession(s)? If yes, state what profession(s) and in what state(s): <input style="width: 100%;" type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
10.	Have you ever been credentialed under any other name(s)? If yes, state name(s) credentialed under: <input style="width: 100%;" type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
11.	Has the Drug Enforcement Administration ever withdrawn your DEA number or warned you, or have you been denied a DEA number? If yes, give details on an attached sheet.	<input type="checkbox"/> Yes <input type="checkbox"/> No

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- Author: guilitaxvz Subject: Sticky Note Date: 2/2/2020 12:57:40 PM
"state board examination, national board examination" changed to "state board examination or national board examination."
- Author: guilitaxvz Subject: Sticky Note Date: 3/2/2020 7:06:19 AM
Q9 - Keep or remove. Would like Board Counsel determination.

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.

Wisconsin Department of Safety and Professional Services

This page contains no comments

12.	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.	<input type="checkbox"/> Yes <input type="checkbox"/> No
13.	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.	<input type="checkbox"/> Yes <input type="checkbox"/> No
14.	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.	<input type="checkbox"/> Yes <input type="checkbox"/> No
15.	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.	<input type="checkbox"/> Yes <input type="checkbox"/> No
16.	Have you ever been diagnosed as having, or have you ever been treated for pedophilia, exhibitionism, or voyeurism? If yes, please explain.	<input type="checkbox"/> Yes <input type="checkbox"/> No
17.	Are you currently engaged in the illegal use of controlled dangerous substances?	<input type="checkbox"/> Yes <input type="checkbox"/> No
18.	If yes, 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.	<input type="checkbox"/> Yes <input type="checkbox"/> 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: / /

Application For Dental Faculty License (2650) (with comments)

Wisconsin Department of Safety and Professional Services

Mail To: P.O. Box 8935
Madison, WI 53708-8935
FAX #: (608) 261-7083
Phone #: (608) 266-2112

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

DENTISTRY EXAMINING BOARD DENTAL LICENSE INFORMATION DENTAL FACULTY INFORMATION

The Board shall grant a license to practice dentistry 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 Dentistry Examining 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 copy of the front and back of a current certificate. This certificate must be signed and dated. See DHS website at <https://www.dhs.wisconsin.gov/ems/licensing/cpr.htm> for a listing of approved programs.
4. **NATIONAL PRACTITIONER DATA BANK** Go to <http://www.npdb-hipdb.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 report you downloaded with their link. Please forward the email and the attached report directly to DSPSCredDentistry@wisconsin.gov. Or, send the original report with the envelope by mail. Please allow 7-10 business days for processing once received here in the Department. Further questions regarding this process may be directed to the Data Bank Help Line at 1-800-767-6732.
If processed, mail all contents, including the envelope, to the Dentistry Examining Board at the above address. Further questions regarding this form may be directed to the Data Bank Help Line at 1-800-767-6732.
5. **FACULTY DENTIST CERTIFICATION OF OFFER OF EMPLOYMENT (Form #XXXX)** Complete per form instructions and have the school submit directly to DSPS.
6. **INITIAL INTERVIEW** Once items 1-4 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)**, if applicable.
8. **MALPRACTICE SUITES OR CLAIMS (Form #2829)** and copies of malpractice suite, court documents and allegations and settlement, if applicable.
9. **IS NAME ON ALL CREDENTIALS THE SAME?** If not, submit certified copy of marriage certificate, divorce decree, etc.

NOTE: Please see [Wisconsin Administrative Code Chapter DE 2.015](#) for further information about this credential type.

Page: 1

Author: [guiltaxvz](#) Subject: Sticky Note Date: 2/2/2020 12:33:47 PM
Reference to new form added

Author: [guiltaxvz](#) Subject: Sticky Note Date: 2/2/2020 12:33:26 PM
word "may" inserted and the word "will" deleted

Wisconsin Department of Safety and Professional Services

IMPORTANT NOTE: YOUR APPLICATION IS NOT COMPLETE UNTIL ALL OF THE DOCUMENTS LISTED ON PAGE 1 OF THIS FORM (#2650) HAVE BEEN RECEIVED.

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ARE YOU A VETERAN? If yes, please view the Department website at <https://dps.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.WISVETS.com for assistance in obtaining your DVA Voucher Code and/or documents related to your training.

- Author: guilitaxv Subject: Sticky Note Date: 2/2/2020 1:12:28 PM
Comment added as list of requirements removed from this section of the application.
- Author: guilitaxv Subject: Sticky Note Date: 2/2/2020 1:13:02 PM
VA information moved back into the application since it collects information such as the VA code.
- Author: guilitaxv Subject: Sticky Note Date: 2/2/2020 1:13:44 PM
was "state board examination, national board examination" changed to "state board examination or national board examination."
- Author: guilitaxv Subject: Sticky Note Date: 3/2/2020 7:03:41 AM
Keep or remove Q9. (Committee wanted to remove question from Form 512.)

ANSWER THE FOLLOWING QUESTIONS (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.	<input type="checkbox"/> Yes <input type="checkbox"/> No
2.	Have you ever failed to pass any state board examination or national board examination? If yes, provide details below: (Original pass/fail cards required.)	<input type="checkbox"/> Yes <input type="checkbox"/> 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.	<input type="checkbox"/> Yes <input type="checkbox"/> 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.	<input type="checkbox"/> Yes <input type="checkbox"/> 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).	<input type="checkbox"/> Yes <input type="checkbox"/> 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.	<input type="checkbox"/> Yes <input type="checkbox"/> 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).	<input type="checkbox"/> Yes <input type="checkbox"/> 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 cards required.)	<input type="checkbox"/> Yes <input type="checkbox"/> No
9.	Are you registered or licensed in any other profession(s)? If yes, state what profession(s) and in what state(s):	<input type="checkbox"/> Yes <input type="checkbox"/> No
10.	Have you ever been credentialed under any other name(s)? If yes, state name(s) credentialed under:	<input type="checkbox"/> Yes <input type="checkbox"/> No
11.	Has the Drug Enforcement Administration ever withdrawn your DEA number or warned you, or have you been denied a DEA number? If yes, give details on an attached sheet.	<input type="checkbox"/> Yes <input type="checkbox"/> No

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: / /

- Author: guilitaxv Subject: Sticky Note Date: 2/2/2020 12:34:29 PM
Wording of third option updated
- Author: guilitaxv Subject: Sticky Note Date: 2/2/2020 12:35:06 PM
Portion to be completed by Dean of a WI School of Dentistry moved to an independent form.

NEW FORM – Faculty Dentist Certification of Offer of Employment (associated with Form 2650)

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

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)

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 DSPCredDentistry@wisconsin.gov.

School Name:

School Address (street, city):

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

Application For Dental Permit to Administer Conscious Sedation (Form 2759)

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 PERMIT TO ADMINISTER CONSCIOUS SEDATION

Under Wisconsin law, the Department must deny your application if you are liable for delinquent State Taxes or Child Support (Wis. Stats. § 440.12).

PLEASE TYPE OR PRINT IN INK <input type="checkbox"/> Your name and address are available to the public. Check box to withhold street address/PO Box number from lists of 10 or more credential holders (Wis. Stat. § 440.14).			
Last Name	First Name	MI	Former / Maiden Name(s)
<input style="width:95%;" type="text"/>	<input style="width:95%;" type="text"/>	<input style="width:95%;" type="text"/>	<input style="width:95%;" type="text"/>
Address (street, city, state, zip)		Daytime Telephone Number	
<input style="width:95%;" type="text"/>		<input style="width:15%; height:20px;" type="text"/> - <input style="width:15%; height:20px;" type="text"/> - <input style="width:15%; height:20px;" type="text"/>	
Mailing Address (if different)		Date of Birth	
<input style="width:95%;" type="text"/>		<input style="width:15%; height:20px;" type="text"/> / <input style="width:15%; height:20px;" type="text"/> / <input style="width:15%; height:20px;" type="text"/>	
Social Security #		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.	
<input style="width:15%; height:20px;" type="text"/> - <input style="width:15%; height:20px;" type="text"/> - <input style="width:15%; height:20px;" type="text"/>			
Ethnicity/gender status information is optional. Ethnicity: <input type="checkbox"/> White, not of Hispanic origin <input type="checkbox"/> American Indian or Alaskan <input type="checkbox"/> Hispanic <input type="checkbox"/> Black, not of Hispanic origin <input type="checkbox"/> Asian or Pacific Islander <input type="checkbox"/> Other Sex: <input type="checkbox"/> M <input type="checkbox"/> F			
Email Address			
<input style="width:95%;" type="text"/>			
List your Wisconsin Dentist Credential Number:		<input style="width:95%;" type="text"/>	

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)

Wisconsin Department of Safety and Professional Services

CHECK THE BELOW CLASS FOR WHICH YOU ARE SEEKING CERTIFICATION (CLASS III, CLASS II OR CLASS I). Under 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/DEEP SEDATION AND GENERAL ANESTHESIA:** This permit allows a Dentist to do all of the following: deep sedation, general anesthesia, conscious sedation-parenteral, and conscious sedation-enteral. Dentists who hold Class III Permits do not have to obtain any other permit.
- Completed application (**Form #2759**)
 - Fee attached to this application
 - Proof of one of the following:
 - ▶ A Board-approved post-doctoral training program in the administration of deep sedation and general anesthesia (**Form #2758**).
 - OR**
 - ▶ A post-doctoral anesthesiology program in anesthesiology, which is approved by the Accreditation Council for Graduate Medical Education (**Form #2758**).
 - OR**
 - ▶ Minimum of one-year of advanced clinical training in anesthesiology (**Form #2758**).
 - OR**
 - ▶ Proof you have been utilizing general anesthesia for at least five (5) years prior to January 1, 2007 (**complete Class III Practice below**).
 - Submit current copy of Advanced Cardiac Life Support Certificate (**front/back**).

NOTE: If the Dentist is a pediatric specialist, the Dentist may substitute proof of Certification in Pediatric Advanced Life Support.

CLASS III PRACTICE: Account for all activities and practice utilizing general anesthesia or deep sedation for the last five (5) years prior to January 1, 2007. All time and dates must be accounted for. (**Attach additional sheet, if necessary.**)

<p>1. Location</p> <div style="border: 1px solid black; height: 20px; width: 95%; margin-bottom: 5px;"></div> <p>Type of Anesthesia</p> <div style="border: 1px solid black; height: 20px; width: 95%; margin-bottom: 5px;"></div> <p>Frequency (Ave. Use Per Week) <input style="width: 150px;" type="text"/></p> <p>Any Adverse Occurrences? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, provide Form #2764 for each occurrence.)</p>	<p>Dates (Month/Year)</p> <p>(From)</p> <div style="display: flex; justify-content: center; gap: 10px;"> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> / <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> </div> <p>(To)</p> <div style="display: flex; justify-content: center; gap: 10px;"> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> / <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> </div>
<p>2. Location</p> <div style="border: 1px solid black; height: 20px; width: 95%; margin-bottom: 5px;"></div> <p>Type of Anesthesia</p> <div style="border: 1px solid black; height: 20px; width: 95%; margin-bottom: 5px;"></div> <p>Frequency (Ave. Use Per Week) <input style="width: 150px;" type="text"/></p> <p>Any Adverse Occurrences? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, provide Form #2764 for each occurrence.)</p>	<p>Dates (Month/Year)</p> <p>(From)</p> <div style="display: flex; justify-content: center; gap: 10px;"> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> / <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> </div> <p>(To)</p> <div style="display: flex; justify-content: center; gap: 10px;"> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> / <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> </div>
<p>3. Location</p> <div style="border: 1px solid black; height: 20px; width: 95%; margin-bottom: 5px;"></div> <p>Type of Anesthesia</p> <div style="border: 1px solid black; height: 20px; width: 95%; margin-bottom: 5px;"></div> <p>Frequency (Ave. Use Per Week) <input style="width: 150px;" type="text"/></p> <p>Any Adverse Occurrences? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, provide Form #2764 for each occurrence.)</p>	<p>Dates (Month/Year)</p> <p>(From)</p> <div style="display: flex; justify-content: center; gap: 10px;"> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> / <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> </div> <p>(To)</p> <div style="display: flex; justify-content: center; gap: 10px;"> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> / <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> </div>

Wisconsin Department of Safety and Professional Services

<p>4. Location</p> <input style="width: 95%; height: 25px;" type="text"/> <p>Type of Anesthesia</p> <input style="width: 95%; height: 25px;" type="text"/> <p>Frequency (Ave. Use Per Week) <input style="width: 200px; height: 25px;" type="text"/></p> <p>Any Adverse Occurrences? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, provide Form #2764 for each occurrence.)</p>	<p>Dates (Month/Year)</p> <p>(From)</p> <input style="width: 30px; height: 25px;" type="text"/> / <input style="width: 30px; height: 25px;" type="text"/> <p>(To)</p> <input style="width: 30px; height: 25px;" type="text"/> / <input style="width: 30px; height: 25px;" type="text"/>
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<p>5. Location</p> <input style="width: 95%; height: 25px;" type="text"/> <p>Type of Anesthesia</p> <input style="width: 95%; height: 25px;" type="text"/> <p>Frequency (Ave. Use Per Week) <input style="width: 200px; height: 25px;" type="text"/></p> <p>Any Adverse Occurrences? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, provide Form #2764 for each occurrence.)</p>	<p>Dates (Month/Year)</p> <p>(From)</p> <input style="width: 30px; height: 25px;" type="text"/> / <input style="width: 30px; height: 25px;" type="text"/> <p>(To)</p> <input style="width: 30px; height: 25px;" type="text"/> / <input style="width: 30px; height: 25px;" type="text"/>
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CERTIFICATION FOR CLASS II/CONSCIOUS SEDATION - Parenteral: This permit allows a Dentist to do the following: conscious sedation-parenteral and conscious sedation-enteral. Dentists who hold a Class II Permit do not have to obtain a Class I Permit.

Completed application (**Form #2759**)

Fee attached to this application

Proof of one of the following:

A Board-approved training course which includes (**Form #2758**):

- ◆ A minimum of 60 hours of didactic instruction which addresses the physical evaluation of patients, IV sedation, and emergency management
- ◆ 20 clinical cases of managing parenteral routes of administration

OR

- ▶ Graduate level training approved by the Board that at the minimum meets the above requirements (**Form # 2758**)

OR

- ▶ Proof that the Dentist has administered conscious sedation-**parenterally** on an outpatient basis for five (5) years preceding January 1, 2007 (**complete Class II Practice below**)

Submit current copy of Advanced Cardiac Life Support Certificate (**front/back**)

NOTE: If the Dentist is a pediatric specialist, the Dentist may substitute proof of Certification in Pediatric Advanced Life Support.

CLASS II PRACTICE: Account for all activities and practice for administering conscious sedation-**parenterally** on an outpatient basis for the last five (5) years preceding January 1, 2007. All time and dates must be accounted for (Attach additional sheet, if necessary.)

<p>1. Location</p> <input style="width: 95%; height: 25px;" type="text"/> <p>Type of Anesthesia</p> <input style="width: 95%; height: 25px;" type="text"/> <p>Frequency (Ave. Use Per Week) <input style="width: 200px; height: 25px;" type="text"/></p> <p>Any Adverse Occurrences? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, provide Form #2764 for each occurrence.)</p>	<p>Dates (Month/Year)</p> <p>(From)</p> <input style="width: 30px; height: 25px;" type="text"/> / <input style="width: 30px; height: 25px;" type="text"/> <p>(To)</p> <input style="width: 30px; height: 25px;" type="text"/> / <input style="width: 30px; height: 25px;" type="text"/>
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Wisconsin Department of Safety and Professional Services

CLASS II PRACTICE: (continued) Account for all activities and practice for administering conscious sedation-**parenterally** on an outpatient basis for the last five (5) years preceding January 1, 2007. **All** time and dates must be accounted for (Attach additional sheet, if necessary.)

2. Location

Type of Anesthesia

Frequency (Ave. Use Per Week)

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

Dates (Month/Year)
 (From)
 /

(To)
 /

3. Location

Type of Anesthesia

Frequency (Ave. Use Per Week)

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

Dates (Month/Year)
 (From)
 /

(To)
 /

4. Location

Type of Anesthesia

Frequency (Ave. Use Per Week)

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

Dates (Month/Year)
 (From)
 /

(To)
 /

5. Location

Type of Anesthesia

Frequency (Ave. Use Per Week)

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

Dates (Month/Year)
 (From)
 /

(To)
 /

Wisconsin Department of Safety and Professional Services

CERTIFICATION FOR CLASS I/CONSCIOUS SEDATION - Enteral: This permit only allows a Dentist to do oral conscious sedation-enteral.

Completed application (**Form #2759**)

Fee attached to this application

A Board-approved training course or graduate level training course that includes (**Form #2758**):

▶ 18 hours of didactic instruction which addresses physical evaluation of patients, conscious sedation-enteral, emergency management, and conforms to the principles in part one or part 3 of the American Dental Association's "Guidelines for Teaching the Comprehensive Control of Anxiety and Pain in Dentistry."

▶ 20 clinical cases using an enteral route of administration to achieve conscious sedation that may include group observation.

Submit current copy of Basic Cardiac Life Support Certificate (**front and back**) and a Board-approved course in airway management.

OR

Submit copy of current Advanced Cardiac Life Support Certificate (**front and back**).

NOTE: If the Dentist is sedating patients age 14 or younger, the Dentist must provide proof of Certification in Pediatric Advanced Life Support.

No permit is required for anxiolysis or nitrous oxide inhalation. "Anxiolysis" means the use of medication to relieve anxiety before or during a dental procedure, which produces a minimally depressed level of consciousness, during which the patient's eyes are open and the patient retains the ability to maintain an airway independently and to respond appropriately to physical and verbal command.

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: / /

Conscious Sedation Provider School Verification Form (Form 2758)

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

CONSCIOUS SEDATION PROVIDER SCHOOL 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** 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) - -

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

/ /
Applicant Signature Date

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

AFFIDAVIT FOR CLASS III

Name of School/Provider:

Location of School/Provider: (city, state)

Date of Hours Completion: / /

I attest to the fact that the above named applicant completed:

Check one box below.

Board approved post-doctoral training in the administration of deep sedation and general anesthesia.

OR

Successful completion of a post-doctoral training program in anesthesiology that is approved by the Accreditation Council for Graduate Medical Education.

OR

Successful completion of a minimum of one year advanced clinical training in anesthesiology provided it meets the objectives set forth in part 2 of the American Dental Association's "Guidelines for Teaching the Comprehensive Control of Anxiety and Pain in Dentistry."

This School/Provider was Board approved on: / /

/ /
Signature Date

Title

Wisconsin Department of Safety and Professional Services

AFFIDAVIT FOR CLASS II

Name of School/Provider:

Location of School/Provider: (city, state)

Date of Hours Completion:

 / /

I attest to the fact that the above named applicant completed:

Check one box below.

Successfully completed at least 60 hours of didactic instruction which address the physical evaluation of patients, IV sedation, and emergency management and 20 clinical cases managing parenteral routes of administration

OR

Graduate level training approved by the Board, which includes the minimum requirements as set forth above.

This School/Provider was Board approved on:

 / / / /

Signature

Date

Title

AFFIDAVIT FOR CLASS I

Name of School/Provider:

Location of School/Provider: (city, state)

Date of Hours Completion:

 / /

I attest to the fact that the above named applicant completed:

Check one box below.

Has successfully completed at least 18 hours in didactic instruction which addresses physical evaluation of patients, conscious sedation-enteral, emergency management, and conforms to the principles in part one or part 3 of the American Dental Association's "Guidelines for Teaching the Comprehensive Control of Anxiety and Pain in Dentistry" and 20 clinical cases using an enteral route of administration to achieve conscious sedation, which may include group observation.

OR

Graduate level training approved by the Board that, at a minimum, includes the requirements as set forth above.

This School/Provider was Board approved on:

 / / / /

Signature

Date

Title

Report of Adverse Occurrences Related to
Anesthesia Administration (Form 2764)

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: dspd@wisconsin.gov
Website: <http://dspd.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. Dentists shall submit a report within 30-days to the Board of any mortality or other incident, which results in temporary or permanent physical or mental injury requiring hospitalization of a patient during, or as a result of, anesthesia administration under this chapter. The report shall be on a form approved by the Board and 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.
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://dspd.wi.gov>.

Send (**Form #2764**) to the DSPPS office at Wisconsin Dentistry Examining Board, DSPPS, 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 dspdcreddentistry@wisconsin.gov.

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

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
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/>
Address (street, city, state, zip)			Daytime Telephone Number
<input type="text"/>			<input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Date of Occurrence:			
<input type="text"/> <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>			
Patient's Reaction:			
<input type="text"/>			
Name(s)/Telephone Numbers of all participants in dental procedure and any witness to adverse occurrence:			
Name	<input type="text"/>	Daytime Telephone Number	<input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Name	<input type="text"/>	Daytime Telephone Number	<input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Name	<input type="text"/>	Daytime Telephone Number	<input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Type of Dental Procedures performed: (provide detailed description)			
<input type="text"/>			
Description of the preoperative physical condition of the patient:			
<input type="text"/>			
Detailed description of techniques utilized in the administration of all drugs used during dental procedure:			
<input type="text"/>			
Description of the adverse occurrence, including symptoms of any complications, treatment given to patient, and patient response to the treatment:			
<input type="text"/>			
Description of patient's condition upon termination of any dental procedures undertaken:			
<input type="text"/>			

Please provide all dental charting relevant to this occurrence.

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.	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>
2.	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>
3.	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>
4.	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>
5.	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>
6.	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>
7.	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>
8.	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>
9.	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>
10.	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>

Drugs Administered During Procedure(s):

	Name of Drug	Dosage Strength and Form	Quantity
11.	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>
12.	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>
13.	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>
14.	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>
15.	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>
16.	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>
17.	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>
18.	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>
19.	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>
20.	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>

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

Signature: Date: / /

Title:

Application to Practice Dentistry without Compensation (Form 2850)

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

INSTRUCTIONS TO APPLICANTS FOR A WISCONSIN TEMPORARY PERMIT TO PRACTICE DENTISTRY WITHOUT COMPENSATION

- Applicants applying for a temporary dentistry permit must hold a current license, which has not been suspended or revoked.

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

1. **Application for Temporary Permit to Practice Dentistry without Compensation (Form #2850).**
2. **Evidence of Satisfactory Completion of Clinical and Laboratory Examination and National Board Examination:** Original score card(s) 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. You may submit an online request at <https://www.ada.org/1635.aspx>. Please request the testing agency to mail your scores directly to DSPS at the above address.

The Board accepts the following exams: CRDTS, WREB, CDCA, SRTA and CITA.
 - The Board accepts The Commission on Dental Competency Assessments (CDCA), formerly Northeast Regional Examination (NERB) taken after September 28, 2000.
 - OR the applicant has successfully completed a Board specialty certification examination of an American Dental Association accredited specialty within the previous 10 years.
3. **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 #2850**) or request them to send it directly to DSPS at the above address.
4. **Evidence of active practice:** You must have been engaged in the active practice of dentistry for at least 48 of the 60 months preceding application in one or more jurisdictions in which you hold a current license in good standing.
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. **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 DHS website at <http://dhs.wisconsin.gov> for a listing of approved programs.
7. **National Practitioner Data Bank:** Go to <http://www.npdb-hipdb.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 report you downloaded with their link. Please forward the email and the attached report directly to DSPSCredDentistry@wi.gov. Or, send the original report with the envelope by mail. Please allow 7-10 business days for processing once received here in the Department. Further questions regarding this process may be directed to the Data Bank Help Line at 1-800-767-6732.

Purpose of a Temporary Permit

The temporary permit will be issued only for dental practice 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. This permit may be renewed at the discretion of the Dentistry Examining Board.

Denial of a Temporary Permit

A temporary permit may be denied by the Board for good cause, including the following:

- a. any violations of the Wisconsin Administrative Code or Statutes relating to the practice of dentistry
- b. pending disciplinary action in another state
- c. fraudulent or misrepresented information on the application

Additional Information

All documentation must be received in this office prior to issuance of the temporary permit. **No** applicant may begin providing services in Wisconsin until the temporary permit is received.

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 TEMPORARY PERMIT TO PRACTICE DENTISTRY WITHOUT COMPENSATION

Under Wisconsin law, the Department must deny your application if you are liable for delinquent State Taxes or Child Support (Wis. Stats. § 440.12).

PLEASE TYPE OR PRINT IN INK

Your name and address are available to the public. Check box to withhold street address/PO Box number from lists of 10 or more credential holders (Wis. Stat. § 440.14).

Last Name <input type="text"/>	First Name <input type="text"/>	MI <input type="text"/>	Former / Maiden Name(s) <input type="text"/>
Address (street, city, state, zip) <input type="text"/>		Daytime Telephone Number <input type="text"/> - <input type="text"/> - <input type="text"/>	
Mailing Address (if different) <input type="text"/>		Date of Birth <input type="text"/> / <input type="text"/> / <input type="text"/>	
Social Security # <input type="text"/> - <input type="text"/> - <input type="text"/>	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: <input type="checkbox"/> White, not of Hispanic origin <input type="checkbox"/> American Indian or Alaskan <input type="checkbox"/> Hispanic <input type="checkbox"/> Black, not of Hispanic origin <input type="checkbox"/> Asian or Pacific Islander <input type="checkbox"/> Other Sex: <input type="checkbox"/> M <input type="checkbox"/> F			
Have you ever been licensed in Wisconsin as a Dentist?		<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, list your credential number: <input type="text"/>
Email Address <input type="text"/>			
School Name <input type="text"/>	School Address (street, city, state) <input type="text"/>		
Date Degree Conferred <input type="text"/> / <input type="text"/> / <input type="text"/>	Degree <input type="text"/>	Specialty <input type="text"/>	

Wisconsin Department of Safety and Professional Services

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

- Application (**Form #2850**)
- Certificate of Professional Education (**Form #1471**)
- Current CPR/AED Certificate
- Letters from all state board where licensed, active and inactive
- Evidence of satisfactory completion of clinical and laboratory examination and national board examination, original pass and fail
- National Practitioner Data Bank Report
- Malpractice Suits or Claims (**Form #2829**) and copies of malpractice suit, court documents with allegations and settlement, if applicable
- Convictions and Pending Charges (**Form #2252**), if applicable

Have you been tested by a Regional Dental Testing Service? Yes No If yes, submit original score card(s) of certification/notification of passing/failing and date.

If yes, please indicate which examination:

- | | |
|--|--|
| <input type="checkbox"/> The Commission on Dental Competency Assessments (CDCA), Formerly Northern Regional Examining Board (NERB) | <input type="checkbox"/> Central Regional Dental Testing Score (CRDTS) |
| <input type="checkbox"/> Western Regional Examining Board (WREB) | <input type="checkbox"/> Southern Regional Testing Agency (SRTA) |
| | <input type="checkbox"/> 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 card(s) from the National Boards

ACTIVE PRACTICE: Applicants for temporary permit to practice dentistry without compensation must hold a current license, which has not been suspended or revoked.

PRACTICE: Account for all activities and practice starting from the date of graduation to the present time. Must include professional and nonprofessional activities. <u>All time and dates must be accounted for.</u> (Attach additional sheets, if necessary.)				
Employer Institution Activity	Location of Employment (City/State)	Dates Employed (Month/Year)	# of Hours per Week	The Capacity in Which You Are/Were Employed
<div style="border: 1px solid black; width: 100%; height: 100%;"></div>	(City) <div style="border: 1px solid black; width: 150px; height: 20px; margin: 2px 0;"></div> (State) <div style="border: 1px solid black; width: 30px; height: 20px; margin: 2px 0;"></div>	(From) <div style="border: 1px solid black; width: 40px; height: 20px; margin: 2px 0;"></div> / <div style="border: 1px solid black; width: 20px; height: 20px; margin: 2px 0;"></div> (To) <div style="border: 1px solid black; width: 40px; height: 20px; margin: 2px 0;"></div> / <div style="border: 1px solid black; width: 20px; height: 20px; margin: 2px 0;"></div>	<div style="border: 1px solid black; width: 40px; height: 20px;"></div>	<div style="border: 1px solid black; width: 100%; height: 100%;"></div>
<div style="border: 1px solid black; width: 100%; height: 100%;"></div>	(City) <div style="border: 1px solid black; width: 150px; height: 20px; margin: 2px 0;"></div> (State) <div style="border: 1px solid black; width: 30px; height: 20px; margin: 2px 0;"></div>	(From) <div style="border: 1px solid black; width: 40px; height: 20px; margin: 2px 0;"></div> / <div style="border: 1px solid black; width: 20px; height: 20px; margin: 2px 0;"></div> (To) <div style="border: 1px solid black; width: 40px; height: 20px; margin: 2px 0;"></div> / <div style="border: 1px solid black; width: 20px; height: 20px; margin: 2px 0;"></div>	<div style="border: 1px solid black; width: 40px; height: 20px;"></div>	<div style="border: 1px solid black; width: 100%; height: 100%;"></div>
<div style="border: 1px solid black; width: 100%; height: 100%;"></div>	(City) <div style="border: 1px solid black; width: 150px; height: 20px; margin: 2px 0;"></div> (State) <div style="border: 1px solid black; width: 30px; height: 20px; margin: 2px 0;"></div>	(From) <div style="border: 1px solid black; width: 40px; height: 20px; margin: 2px 0;"></div> / <div style="border: 1px solid black; width: 20px; height: 20px; margin: 2px 0;"></div> (To) <div style="border: 1px solid black; width: 40px; height: 20px; margin: 2px 0;"></div> / <div style="border: 1px solid black; width: 20px; height: 20px; margin: 2px 0;"></div>	<div style="border: 1px solid black; width: 40px; height: 20px;"></div>	<div style="border: 1px solid black; width: 100%; height: 100%;"></div>

Wisconsin Department of Safety and Professional Services

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

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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.

SPECIFIC AREA OF STATE OR EVENT WHERE YOU WILL WORK: (List the location and dates you will be working (not to exceed 10 days in one year).

Location of Employment (City/State)	Dates Employed (Month/Year)
(City) <input style="width: 95%;" type="text"/> (State) <input style="width: 100px;" type="text"/>	(From) <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> / <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> (To) <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> / <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/>
(City) <input style="width: 95%;" type="text"/> (State) <input style="width: 100px;" type="text"/>	(From) <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> / <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> (To) <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> / <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/>
(City) <input style="width: 95%;" type="text"/> (State) <input style="width: 100px;" type="text"/>	(From) <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> / <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> (To) <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> / <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/>
(City) <input style="width: 95%;" type="text"/> (State) <input style="width: 100px;" type="text"/>	(From) <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> / <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> (To) <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> / <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/>
(City) <input style="width: 95%;" type="text"/> (State) <input style="width: 100px;" type="text"/>	(From) <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> / <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> (To) <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> / <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/>

Wisconsin Department of Safety and Professional Services

ANSWER THE FOLLOWING QUESTIONS (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.	<input type="checkbox"/> Yes <input type="checkbox"/> 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.) <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input type="checkbox"/> Yes <input type="checkbox"/> 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.	<input type="checkbox"/> Yes <input type="checkbox"/> 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.	<input type="checkbox"/> Yes <input type="checkbox"/> 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. If yes, submit Convictions and Pending Charges (Form #2252).	<input type="checkbox"/> Yes <input type="checkbox"/> 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.	<input type="checkbox"/> Yes <input type="checkbox"/> No
7.	Have any suits or claims ever been filed against you as a result of professional services? If yes, Malpractice Suits or Claims (Form #2829).	<input type="checkbox"/> Yes <input type="checkbox"/> No
8.	Have you failed to pass the Central Regional Dental Testing Service Clinical examination, or any other dental hygiene licensing examination? If yes, state which examination, and the date of the examination. (Original pass/fail cards required.)	<input type="checkbox"/> Yes <input type="checkbox"/> No
9.	Are you registered or licensed in any other profession(s)? If yes, state what profession(s) and in what state(s): <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input type="checkbox"/> Yes <input type="checkbox"/> No
10.	Have you ever been credentialed under any other name(s)? If yes, state name(s) credentialed under: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input type="checkbox"/> Yes <input type="checkbox"/> No
11.	Has the Drug Enforcement Administration ever withdrawn your DEA number or warned you, or have you been denied a DEA number? If yes, give details on an attached sheet.	<input type="checkbox"/> Yes <input type="checkbox"/> 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.

Wisconsin Department of Safety and Professional Services

12.	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 13 and 14. If yes, please explain.	<input type="checkbox"/> Yes <input type="checkbox"/> No
13.	If yes to question 12, 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.	<input type="checkbox"/> Yes <input type="checkbox"/> No
14.	If yes to question 12, 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.	<input type="checkbox"/> Yes <input type="checkbox"/> No
15.	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.	<input type="checkbox"/> Yes <input type="checkbox"/> No
16.	Have you ever been diagnosed as having, or have you ever been treated for pedophilia, exhibitionism, or voyeurism? If yes, please explain.	<input type="checkbox"/> Yes <input type="checkbox"/> No
17.	Are you currently engaged in the illegal use of controlled dangerous substances?	<input type="checkbox"/> Yes <input type="checkbox"/> No
18.	If yes to question 17, 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.	<input type="checkbox"/> Yes <input type="checkbox"/> 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: / /

(DH) Application For Dental Hygiene License (Form 511)

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 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 <http://dhs.wisconsin.gov> for a listing of approved programs.

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.

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 LICENSE

Under Wisconsin law, the Department must deny your application if you are liable for delinquent State Taxes or Child Support (Wis. Stats. § 440.12).

PLEASE TYPE OR PRINT IN INK				<input type="checkbox"/> Your name and address are available to the public. Check box to withhold street address/PO Box number from lists of 10 or more credential holders (Wis. Stat. § 440.14).
Last Name <input type="text"/>	First Name <input type="text"/>	MI <input type="text"/>	Former / Maiden Name(s) <input type="text"/>	
Address (street, city, state, zip) <input type="text"/>			Daytime Telephone Number <input type="text"/> - <input type="text"/> - <input type="text"/>	
Mailing Address (if different) <input type="text"/>			Date of Birth <input type="text"/> / <input type="text"/> / <input type="text"/>	
Social Security # <input type="text"/> - <input type="text"/> - <input type="text"/>		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: <input type="checkbox"/> White, not of Hispanic origin <input type="checkbox"/> American Indian or Alaskan <input type="checkbox"/> Hispanic <input type="checkbox"/> Black, not of Hispanic origin <input type="checkbox"/> Asian or Pacific Islander <input type="checkbox"/> Other				
Sex: <input type="checkbox"/> M <input type="checkbox"/> F				
Have you ever been licensed in Wisconsin as a Dental Hygienist? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list your credential number: <input type="text"/>				
Email Address <input type="text"/>				
School Name <input type="text"/>			School Address (street, city, state) <input type="text"/>	
Date Degree Conferred <input type="text"/> / <input type="text"/> / <input type="text"/>			Degree <input type="text"/>	Specialty <input type="text"/>

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)**
 \$ 74.00 Initial Credential Fee
 \$ 75.00 State Law Exam
\$149.00 Total Fee Attached
- Endorsement of a State Board**
 \$ 74.00 Initial Credential Fee
 \$ 75.00 State Law Exam
\$149.00 Total Fee Attached

For Receipting Use Only (16)

Wisconsin Department of Safety and Professional Services

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

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

ARE YOU A VETERAN? If yes, please view the Department website at <http://dsps.wi.gov> under "License, Permits, and Registrations" and select "Military Benefits Related to Licensure for Eligible Veterans Services Members and Spouses" 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 the "Professional Credential Renewal Information".

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
<input style="width: 100%; height: 100%;" type="text"/>	(City) <input style="width: 150px;" type="text"/> (State) <input style="width: 30px;" type="text"/> <input style="width: 30px;" type="text"/>	(From) <input style="width: 30px;" type="text"/> <input style="width: 30px;" type="text"/> / <input style="width: 30px;" type="text"/> <input style="width: 30px;" type="text"/> (To) <input style="width: 30px;" type="text"/> <input style="width: 30px;" type="text"/> / <input style="width: 30px;" type="text"/> <input style="width: 30px;" type="text"/>	<input style="width: 50px;" type="text"/>	<input style="width: 100%; height: 100%;" type="text"/>
<input style="width: 100%; height: 100%;" type="text"/>	(City) <input style="width: 150px;" type="text"/> (State) <input style="width: 30px;" type="text"/> <input style="width: 30px;" type="text"/>	(From) <input style="width: 30px;" type="text"/> <input style="width: 30px;" type="text"/> / <input style="width: 30px;" type="text"/> <input style="width: 30px;" type="text"/> (To) <input style="width: 30px;" type="text"/> <input style="width: 30px;" type="text"/> / <input style="width: 30px;" type="text"/> <input style="width: 30px;" type="text"/>	<input style="width: 50px;" type="text"/>	<input style="width: 100%; height: 100%;" type="text"/>
<input style="width: 100%; height: 100%;" type="text"/>	(City) <input style="width: 150px;" type="text"/> (State) <input style="width: 30px;" type="text"/> <input style="width: 30px;" type="text"/>	(From) <input style="width: 30px;" type="text"/> <input style="width: 30px;" type="text"/> / <input style="width: 30px;" type="text"/> <input style="width: 30px;" type="text"/> (To) <input style="width: 30px;" type="text"/> <input style="width: 30px;" type="text"/> / <input style="width: 30px;" type="text"/> <input style="width: 30px;" type="text"/>	<input style="width: 50px;" type="text"/>	<input style="width: 100%; height: 100%;" type="text"/>

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.

ANSWER THE FOLLOWING QUESTIONS: (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.	<input type="checkbox"/> Yes <input type="checkbox"/> 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.) <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input type="checkbox"/> Yes <input type="checkbox"/> 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.	<input type="checkbox"/> Yes <input type="checkbox"/> 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.	<input type="checkbox"/> Yes <input type="checkbox"/> 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. If yes, submit Convictions and Pending Charges (Form #2252).	<input type="checkbox"/> Yes <input type="checkbox"/> 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.	<input type="checkbox"/> Yes <input type="checkbox"/> No
7.	Have any suits or claims ever been filed against you as a result of professional services? If yes, Malpractice Suits or Claims (Form #2829).	<input type="checkbox"/> Yes <input type="checkbox"/> No
8.	Are you registered or licensed in any other profession(s)? If yes, state what profession(s) and in what state(s): <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input type="checkbox"/> Yes <input type="checkbox"/> No
9.	Have you ever been credentialed under any other name(s)? If yes, state name(s) credentialed under: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input type="checkbox"/> Yes <input type="checkbox"/> No

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.

10.	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 11 and 12. If yes, please explain.	<input type="checkbox"/> Yes <input type="checkbox"/> No
11.	If yes to question 10, 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.	<input type="checkbox"/> Yes <input type="checkbox"/> No
12.	If yes to question 10, 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.	<input type="checkbox"/> Yes <input type="checkbox"/> No
13.	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.	<input type="checkbox"/> Yes <input type="checkbox"/> No
14.	Have you ever been diagnosed as having, or have you ever been treated for pedophilia, exhibitionism, or voyeurism? If yes, please explain.	<input type="checkbox"/> Yes <input type="checkbox"/> No
15.	Are you currently engaged in the illegal use of controlled dangerous substances?	<input type="checkbox"/> Yes <input type="checkbox"/> No
16.	If yes to question 15, 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.	<input type="checkbox"/> Yes <input type="checkbox"/> 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.

Wisconsin Department of Safety and Professional Services

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: / /

(DH) Application For Dental Hygiene Certificate to
Administer Local Anesthesia (Form 2455)

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

PLEASE TYPE OR PRINT IN INK <input type="checkbox"/> Your name and address are available to the public. Check box to withhold street address/PO Box number from lists of 10 or more credential holders (Wis. Stat. § 440.14).			
Last Name <input style="width:95%;" type="text"/>	First Name <input style="width:95%;" type="text"/>	MI <input style="width:95%;" type="text"/>	Former / Maiden Name(s) <input style="width:95%;" type="text"/>
Address (street, city, state, zip) <input style="width:95%;" type="text"/>		Daytime Telephone Number <input style="width:15%; text-align:center;" type="text"/> <input style="width:15%; text-align:center;" type="text"/> <input style="width:15%; text-align:center;" type="text"/> - <input style="width:15%; text-align:center;" type="text"/>	
Mailing Address (if different) <input style="width:95%;" type="text"/>		Date of Birth <input style="width:15%; text-align:center;" type="text"/> <input style="width:15%; text-align:center;" type="text"/> / <input style="width:15%; text-align:center;" type="text"/> <input style="width:15%; text-align:center;" type="text"/> / <input style="width:15%; text-align:center;" type="text"/> <input style="width:15%; text-align:center;" type="text"/> <input style="width:15%; text-align:center;" type="text"/> <input style="width:15%; text-align:center;" type="text"/>	
Social Security # <input style="width:15%; text-align:center;" type="text"/> <input style="width:15%; text-align:center;" type="text"/> <input style="width:15%; text-align:center;" type="text"/> - <input style="width:15%; text-align:center;" type="text"/> <input style="width:15%; text-align:center;" type="text"/> <input style="width:15%; text-align:center;" type="text"/> <input style="width:15%; text-align:center;" type="text"/>		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: <input type="checkbox"/> White, not of Hispanic origin <input type="checkbox"/> American Indian or Alaskan <input type="checkbox"/> Hispanic <input type="checkbox"/> Black, not of Hispanic origin <input type="checkbox"/> Asian or Pacific Islander <input type="checkbox"/> Other Sex: <input type="checkbox"/> M <input type="checkbox"/> F			
Wisconsin Dental Hygienist License Number:		<input style="width:95%;" type="text"/>	
Email Address <input style="width:95%;" type="text"/>			
School Name <input style="width:95%;" type="text"/>		School Address (street, city, state) <input style="width:95%;" type="text"/>	
Course Title <input style="width:95%;" type="text"/>		Date Course Completed <input style="width:15%; text-align:center;" type="text"/> <input style="width:15%; text-align:center;" type="text"/> / <input style="width:15%; text-align:center;" type="text"/> <input style="width:15%; text-align:center;" type="text"/> / <input style="width:15%; text-align:center;" type="text"/> <input style="width:15%; text-align:center;" type="text"/> <input style="width:15%; text-align:center;" type="text"/>	
APPLICATION IS NOT COMPLETE UNTIL THE FOLLOWING DOCUMENTS HAVE BEEN RECEIVED: <ul style="list-style-type: none"> • A copy of current CPR/AED Certificate. (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), applicable only if injection was given under Dentist supervision and not during coursework. 			

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: / /

(DH) Certification of Inferior Alveolar Injection (Form 2458)

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

CERTIFICATE OF INFERIOR ALVEOLAR INJECTION

To be completed by supervising dentist if injection was given under dentist supervision and not during course work.

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

Applicant:

Last Name	First Name	MI	Former / Maiden Name(s)
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

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 that 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

(DH) Local Anesthesia Certificate of Completion (Form 2457)

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

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 at the above address.

Last Name	First Name	MI	Former / Maiden Name(s)
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

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. You may fax/email with facility cover sheet/letter to: (608) 251-3036 or dspscredentistry@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)

Inferior alveolar injection completed on a non-classmate patient as part of course work. (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

(DH) Application for Dental Hygiene to Administer Nitrous
Oxide (Form 3163)

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 NITROUS OXIDE

Under Wisconsin law, the Department must deny your application if you are liable for delinquent State Taxes or Child Support (Wis. Stats. § 440.12).

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

Last Name		First Name	MI	Former / Maiden Name(s)
<input type="text"/>		<input type="text"/>	<input type="text"/>	<input type="text"/>
Address (street, city, state, zip)			Daytime Telephone Number	
<input type="text"/>			<input type="text"/> - <input type="text"/> - <input type="text"/>	
Mailing Address (if different)			Date of Birth	
<input type="text"/>			<input type="text"/> / <input type="text"/> / <input type="text"/>	
Social Security #		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.		
<input type="text"/> - <input type="text"/> - <input type="text"/>				
Ethnicity/gender status information is optional.				
Ethnicity: <input type="checkbox"/> White, not of Hispanic origin <input type="checkbox"/> American Indian or Alaskan <input type="checkbox"/> Hispanic				
<input type="checkbox"/> Black, not of Hispanic origin <input type="checkbox"/> Asian or Pacific Islander <input type="checkbox"/> Other				
Sex: <input type="checkbox"/> M <input type="checkbox"/> F				
Email Address				
<input type="text"/>				
Wisconsin Dental Hygienist License #: <input type="text"/>				
School Name			School Address (street, city, state)	
<input type="text"/>			<input type="text"/>	
Course Title			Date Course Completed	
<input type="text"/>			<input type="text"/> / <input type="text"/> / <input type="text"/>	

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**).

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>.

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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: / /

(DH) Nitrous Oxide Certificate of Completion (Form 3164)

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

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)
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

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.

<input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Applicant Signature	Date

SCHOOL/COURSE PROVIDER: Certify completion below and return directly to DSPS: You may fax/email with facility cover sheet/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 § DE15.05.

<input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Signature	Date

Title

(DH) Application for Temporary Permit to Practice Dental Hygiene
Without Compensation (2853)

Wisconsin Department of Safety and Professional Services

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Madison, WI 53708-8935
FAX #: (608) 251-3036
Phone #: (608) 266-2112

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DENTISTRY EXAMINING BOARD

INSTRUCTIONS TO APPLICANTS FOR A WISCONSIN TEMPORARY PERMIT TO PRACTICE DENTAL HYGIENE WITHOUT COMPENSATION

IMPORTANT:

Applicants applying for a temporary dental hygiene permit must hold a current license, which has not been suspended or revoked. **The applicant must have reputably engaged in the practice of dental hygiene for at least 350 hours within the 12-month period preceding application.**

1. **Complete Application (Form #2853)**
2. **Evidence of Satisfactory Completion of Clinical and Laboratory Examination and National Board Examination:** You must pass a clinical and laboratory examination for licensure from a dental testing service or regional board examination or a state board examination in another state where the licensure requirements are equivalent to those of Wisconsin. The Board accepts Northeast Regional examination (NERB) taken after September 28, 2000. Applicants who have written a state board examination must submit with their application a copy of the state's rules and regulations pertaining to the practice of dental hygiene that were in effect at the time of examination. The Wisconsin Dental Examining Board has not approved any state board examination. Applicants who wish to rely on a state board examination must prove, by a copy of the state's rules, that the examination meets the Wisconsin Board's standards. (Clinical exam on a human subject, substantially equivalent to the CRDTS, Central Regional Dental Testing Service examination) The Board will review the state's rules and made a decision on equivalency.
Other State Board Examination (Applicants who have written a state board examination): Must submit with their application a copy of the state's rules and regulations pertaining to the practice of dental hygiene that were in effect at the time of examination. Wisconsin has not approved any state board examination. Applicants who wish to rely on a state board examination must prove, by a copy of the state's rules, that the examination meets the Wisconsin Board's standards. Clinical exam on a human subject, substantially equivalent to the CRDTS, Central Regional Dental Testing Service examination. The Board will review the state's rules and make a decision on equivalency.
3. **Verification of Licensure in Other State(s):** You are required to submit a photocopy of one current license where you are credentialed.
4. **Certificate of Proficiency in Cardiopulmonary Resuscitation/AED:** Submit a copy of the front and back of a current certificate. See DHS website at <http://dhs.wisconsin.gov> for a listing of approved programs.
5. **Other:** Include explanations on attached sheets, if required, for answers to questions on the Application for Temporary Dental Hygiene Permit (Form #2853).

PURPOSE OF A TEMPORARY PERMIT

The temporary permit will be issued **only** for dental hygiene practice 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. This permit may be renewed at the discretion of the Dentistry Examining Board.

DENIAL OF A TEMPORARY PERMIT

A temporary permit may be denied by the Board for good cause, including the following:

- a. Any violations of the Wisconsin administrative code or statutes relating to the practice of dentistry.
- b. Pending disciplinary action in another state.
- c. Fraudulent or misrepresented information on the application.

ADDITIONAL INFORMATION

All documentation must be received in this office prior to issuance of the temporary permit. **No applicant may begin providing services in Wisconsin until the temporary permit is received.**

Wisconsin Department of Safety and Professional Services

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 Madison, WI 53708-8935
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 Madison, WI 53705
E-Mail: dsps@wisconsin.gov
Website: <http://dsps.wi.gov>

DENTISTRY EXAMINING BOARD

APPLICATION FOR TEMPORARY PERMIT TO PRACTICE DENTAL HYGIENE WITHOUT COMPENSATION

PLEASE TYPE OR PRINT IN INK <input type="checkbox"/> Your name and address are available to the public. Check box to withhold street address/PO Box number from lists of 10 or more credential holders (Wis. Stat. § 440.14).			
Last Name <input type="text"/>	First Name <input type="text"/>	MI <input type="text"/>	Former / Maiden Name(s) <input type="text"/>
Address (street, city, state, zip) <input type="text"/>		Daytime Telephone Number <input type="text"/> - <input type="text"/> - <input type="text"/>	
Mailing Address (if different) <input type="text"/>		Date of Birth <input type="text"/> / <input type="text"/> / <input type="text"/>	
Social Security # <input type="text"/> - <input type="text"/> - <input type="text"/>		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: <input type="checkbox"/> White, not of Hispanic origin <input type="checkbox"/> American Indian or Alaskan <input type="checkbox"/> Hispanic <input type="checkbox"/> Black, not of Hispanic origin <input type="checkbox"/> Asian or Pacific Islander <input type="checkbox"/> Other Sex: <input type="checkbox"/> M <input type="checkbox"/> F			
Have you ever been licensed in Wisconsin as a Dental Hygienist? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list your credential number: <input type="text"/>			
Email Address <input type="text"/>			
School Name <input type="text"/>		School Address (street, city, state) <input type="text"/>	
Date Degree Conferred <input type="text"/> / <input type="text"/> / <input type="text"/>		Degree <input type="text"/>	Specialty <input type="text"/>
Did the American Dental Association accredit this Dental Hygiene School? <input type="checkbox"/> Yes <input type="checkbox"/> No			

Wisconsin Department of Safety and Professional Services

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

- | | |
|---|--|
| <input type="checkbox"/> Application (Form #2853)
<input type="checkbox"/> Photocopy of one current license
<input type="checkbox"/> Convictions and Pending Charges (Form #2252) | <input type="checkbox"/> Malpractice Suits or Claims (Form #2829) and copies of malpractice suit, court documents with allegations and settlement, if applicable
<input type="checkbox"/> Is name on all credentials the same? If not, submit certified copy of marriage certificate, divorce decree, etc. |
|---|--|

Have you been tested by a Regional Dental Testing Service? Yes No If no, provide explanation below.

Have you taken and passed the National Boards? Yes No If no, provide explanation below.

ACTIVE PRACTICE: Applicants for temporary permit to practice dental hygiene without compensation must hold a current license, which has not been suspended or revoked.

Have you been engaged in the active practice of dental hygiene for at least 350 hours within the 12-month period preceding Application?

Yes No

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

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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.

SPECIFIC AREA OF STATE OR EVENT WHERE YOU WILL WORK: List the location and dates you will be working. (Not to exceed 10 days in one year, attach additional sheet(s) if necessary.)

1. Location of Employment (City) <div style="border: 1px solid black; height: 20px; margin-top: 5px;"></div>	(State) <div style="border: 1px solid black; width: 30px; height: 20px; margin-top: 5px;"></div>	Dates Employed (Month/Year) (From) <div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block; margin-right: 5px;"></div> / <div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block; margin-right: 5px;"></div> (To) <div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block; margin-right: 5px;"></div> / <div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block; margin-right: 5px;"></div>
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2. Location of Employment (City) <div style="border: 1px solid black; height: 20px; margin-top: 5px;"></div>	(State) <div style="border: 1px solid black; width: 30px; height: 20px; margin-top: 5px;"></div>	Dates Employed (Month/Year) (From) <div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block; margin-right: 5px;"></div> / <div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block; margin-right: 5px;"></div> (To) <div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block; margin-right: 5px;"></div> / <div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block; margin-right: 5px;"></div>
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3. Location of Employment (City) <div style="border: 1px solid black; height: 20px; margin-top: 5px;"></div>	(State) <div style="border: 1px solid black; width: 30px; height: 20px; margin-top: 5px;"></div>	Dates Employed (Month/Year) (From) <div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block; margin-right: 5px;"></div> / <div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block; margin-right: 5px;"></div> (To) <div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block; margin-right: 5px;"></div> / <div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block; margin-right: 5px;"></div>
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4. Location of Employment (City) <div style="border: 1px solid black; height: 20px; margin-top: 5px;"></div>	(State) <div style="border: 1px solid black; width: 30px; height: 20px; margin-top: 5px;"></div>	Dates Employed (Month/Year) (From) <div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block; margin-right: 5px;"></div> / <div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block; margin-right: 5px;"></div> (To) <div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block; margin-right: 5px;"></div> / <div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block; margin-right: 5px;"></div>
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5. Location of Employment (City) <div style="border: 1px solid black; height: 20px; margin-top: 5px;"></div>	(State) <div style="border: 1px solid black; width: 30px; height: 20px; margin-top: 5px;"></div>	Dates Employed (Month/Year) (From) <div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block; margin-right: 5px;"></div> / <div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block; margin-right: 5px;"></div> (To) <div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block; margin-right: 5px;"></div> / <div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block; margin-right: 5px;"></div>
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Wisconsin Department of Safety and Professional Services

ANSWER THE FOLLOWING QUESTIONS (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.	<input type="checkbox"/> Yes <input type="checkbox"/> 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.) <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input type="checkbox"/> Yes <input type="checkbox"/> 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.	<input type="checkbox"/> Yes <input type="checkbox"/> 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.	<input type="checkbox"/> Yes <input type="checkbox"/> 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. If yes, submit Convictions and Pending Charges (Form #2252).	<input type="checkbox"/> Yes <input type="checkbox"/> 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.	<input type="checkbox"/> Yes <input type="checkbox"/> No
7.	Have any suits or claims ever been filed against you as a result of professional services? If yes, Malpractice Suits or Claims (Form #2829).	<input type="checkbox"/> Yes <input type="checkbox"/> No
8.	Are you registered or licensed in any other profession(s)? If yes, state what profession(s) and in what state(s): <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input type="checkbox"/> Yes <input type="checkbox"/> No
9.	Have you ever been credentialed under any other name(s)? If yes, state name(s) credentialed under: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input type="checkbox"/> Yes <input type="checkbox"/> 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: / /