

# 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

**Ship To:** 1400 E. Washington Avenue  
Madison, WI 53703  
**E-Mail:** [dsps@wisconsin.gov](mailto: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) 261-7083 or [dspscreddentistry@wisconsin.gov](mailto:dspscreddentistry@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**