

Wisconsin Department of Safety and Professional Services

Mail To: P.O. Box 8935
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FAX #: (608) 261-7083
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Ship To: 1400 E. Washington Avenue
Madison, WI 53703
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) 261-7083 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