CERTIFICATION OF LOCAL ANESTHESIA ADMINISTRATION

STATEMENT OF MAINTAINING LOCAL ANESTHESIA SKILLS

Please provide the information requested below concerning your administration of local anesthesia.

Name of Supervising Dentist:	
Address:	
License Number:	Phone:
Dates of Local Anesthesia Administration: From (mo/yr):	To (mo/yr):

Name of Supervising Dentist:	
Address:	
License Number:	Phone:
Dates of Local Anesthesia Administration: From (mo/yr):	To (mo/yr):

Name of Supervising Dentist:	
Address:	
License Number:	Phone:
Dates of Local Anesthesia Administration: From (mo/yr):	To (mo/yr):

Name of Supervising Dentist:	
Address:	
License Number:	Phone:
Dates of Local Anesthesia Administration: From (mo/yr):	To (mo/yr):

I hereby certify that I have maintained my skills in the administration of local anesthesia.

Signature: ______________________________________ Date: _______________________________

Return Completed Form to:
IOWA DENTAL BOARD
400 S.W. 8th St, Suite D
Des Moines, IA 50309-4687
Phone (515) 281-5157
Fax: (515) 281-7969