CERTIFICATION OF LOCAL ANESTHESIA TRAINING

As part of the permit application process, the Iowa Dental Board requires that the institution at which the applicant received her/his local anesthesia training complete this form. The completed form must be mailed directly to the **IOWA DENTAL BOARD.** Any processing fees are the applicant's responsibility.

Print Name _____

Signature _____ **Date** _____

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This portion of the form should be completed by the course instructor.

IT IS HEREBY CERTIFIED THAT _____
(Name of Applicant)

COMPLETED A COURSE IN LOCAL ANESTHESIA AT _____
(Name of School)

LOCATED AT_____
(Full Address of School)

THE TRAINING WAS COMPLETED ON _____.
(Date)

Was the school accredited by the Commission on Dental Accreditation of the American Dental Association at the time the training was completed? ☐ Yes ☐ No

This course included a clinical component requiring demonstration of clinical competence in delivery of maxillary and mandibular injections. ☐ Yes ☐ No

Signature of Course Instructor: _____

Title: _____

Address: _____

Telephone: _____ Fax: _____

Type or Print Name: _____

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