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
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) 261-7083 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

Committed to Equal Opportunity in Employment and Licensing

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

Committed to Equal Opportunity in Employment and Licensing