

#### New Jersey Office of the Attorney General

Division of Consumer Affairs New Jersey State Board of Dentistry 124 Halsey Street, 6th Floor, P.O. Box 45005 Newark, New Jersey 07101 (973) 504-6405

### **Application Instructions**

The State Board of Dentistry has authorized Dental Hygienists to administer certain local anesthetic injections pursuant to <u>N.J.A.C.</u> 13:30-1A.3. Enclosed is your application for a permit to administer local anesthesia. Please read these instructions before you complete the application. The application must be correct and complete. **INCOMPLETE APPLICATIONS WILL BE RETURNED.** 

You must submit proof that you have successfully completed:

- A Board-approved course in the administration of local anesthesia offered in a dental hygiene program approved by the Commission
  on Dental Accreditation, or in an accredited college or university, teaching hospital or other training institution or facility approved
  pursuant to N.J.S.A. 45:6-2. Proof of completion must be on the letterhead of the school or other official document and must include the
  dates of attendance. A copy of your course certificate may be submitted, provided it includes the required information. The
  documentation must include the dates of attendance.
- 2. The written examination in the administration of local anesthesia administered by the Northeast Regional Board of Dental Examiners (N.E.R.B.).

#### PLEASE NOTE:

Please be sure you have signed and properly notarized the enclosed application.

Four (4) continuing education credits devoted to the administration of local anesthesia are required in every other biennial renewal period for the renewal of your permit.



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# Application for Local Anesthesia Permit (Pursuant to N.J.A.C. 13:30-1A.3)

The Board maintains, as part of its responsibilities, a record of your home address, business address and mailing address. You may choose

wh	ich address s	should be used	as your address o	your "address of record." If f record, your mailing addre tt only if you provide anothe	ss will be considered to l	be your addres	ss of record. A post office
	formation that you provide on this application may be subject to public disclosure as required by the Open Public Records Act PRA).						
Ple	ase print clea	arly. You must	answer all of the q	uestions on this application.			
Pe	ersonal In	formation		New Jersey Registered Hy	giene License Number:		
1.	Name	Mr. Mrs.	Last name	First name	Middle initial	(	Maiden name
2.	Address	Ms.	Last name	riist name	Middle ilitiai		waiten name
	Home						
	Home	Street or P.O. Bo	эх	City	State	ZIP code	County
		Т	elephone number (include are	a code)		E-mail address	
	Mailii	Street or P.O. Be	DX.	City	State	ZIP code	County
3.	List the ad	dresses and te	lephone numbers	of all of the offices at whic	h you practice.		
	Busin	ess:	Name of company			m.i. i	
			Name of company			reiepnone nur	nber (include area code)
		Street		City	State	ZIP code	County
	Business:Name of compa		Name of company			Telephone number (include area code)	
		Street		City	State	ZIP code	County
	Busin	ess:	Name of company			Telephone nur	nber (include area code)

ZIP code

County

City

Street

Business:_					
	Name of co	mpany		Telephone num	ber (include area code)
_					
	Street	City	State	ZIP code	County
Business:_	Name of co			T.1. 1	
	Name of co	mpany		Telephone num	ber (include area code)
_	Street	City	State	ZIP code	County
Business:_					
	Name of co	mpany		Telephone number (include area code)	
_	Street	City	State	ZIP code	County
	Adı	ninistration of Local	Anesthesia Tra	ining	
				O	
T4	11.4	41	D 1		
		the successful completion of ase provide the name of the in-			
		ication from the issuing institu			iron, the date the course
Name of Institution					
Tvame of mistration					
Name of course			Date comm	aleted	
Name of course			Date comp	neted	
		<u>Examin</u>	<u>ation</u>		
I have taken and page	ssed the written exa	mination in the administration	of local anesthesia adn	ninistered by the N	ational Regional Board
		e enclosed proof of a passing g			5
Exami	nation score		<del></del>	Date of exan	nination

## **Applicant Certification**

I am aware that if any of the statements made in this application are found to be willfully false, I may be subject to punishment or penalty, a forfeiture of any privileges with regard to the use of local anesthesia and the practice of dentistry.

I also understand that the issuance of this permit is not automatic but will be issued only subsequent to investigation and verification by the New Jersey State Board of Dentistry.

I hereby authorize the release of any a and shall supply to the Board such record			em pertinent to the evaluation of this applied verification of this application.
		_	
Signature of applicant			
Date		_	
Sworn and subscribed to before me this_		_	
lay of	,	_	Affix Seal Here
Month	Year		Affix Seaf Here
		_	
Name of Notary Public (please print	)		

Signature of Notary Public