



Nevada State Board of Dental Examiners

6010 S. Rainbow Blvd., Bldg. A, Ste. 1
Las Vegas, NV 89118
(702) 486-7044 • (800) DDS-EXAM • Fax (702) 486-7046

APPLICATION FOR LOCAL ANESTHESIA PERMIT

(This application must be completed in its entirety)

Name: _____ Home Phone: _____
Mailing address: _____ Work Phone: _____
City, State & Zip: _____ Cell Phone: _____

Dental Hygiene School: _____ Graduation Date: _____
School Address: _____
City, State & Zip: _____

LOCAL ANESTHESIA TRAINING

Training Received at: _____ Graduation Date: _____
Facility Address: _____
City, State & Zip: _____

Type of training received (**mark the appropriate box**):

- Undergraduate (during Dental Hygiene Training) Date of Completion: _____
 Post Graduate (after Dental Hygiene Training) Date of Completion: _____

If local anesthesia training was a **POST GRADUATE** course, a certified copy of the course syllabus **MUST** accompany this application for evaluation of the course content by the Board, otherwise certification cannot be granted.

SIGNATURE OF APPLICANT

I certify that the foregoing statements are true and correct and that I have successfully completed the foregoing course.

Applicant Signature

Date

SUBMIT THIS APPLICATION WITH THE FOLLOWING:

\$25 Application Fee
Completed Certification of Proficiency Form
Certified Copy of Post-Graduate Course Syllabus, if Applicable