



NEVADA STATE BOARD OF DENTAL EXAMINERS
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Certification of Proficiency in the Administration of
Local Anesthesia and Nitrous Oxide Analgesia

I hereby CERTIFY that _____ (*name of applicant*) has successfully completed a course, including administration, in one or both of the following:

(please check and complete appropriate line)

_____ (a) Local Anesthesia on _____ (date)

_____ (b) Nitrous Oxide Oxygen Analgesia on _____ (date)

Original Signature of Dean/Program Director
(No Stamped Signatures)

Printed Name of Dean

Date

*OFFICIAL SEAL OF THE
ACCRREDITED EDUCATIONAL
INSTITUTION*

*This form must be completed and returned by the educational institution only as primary source verification.