



DEPARTMENT OF COMMERCE, COMMUNITY, AND ECONOMIC DEVELOPMENT  
DIVISION OF CORPORATIONS, BUSINESS AND PROFESSIONAL LICENSING  
BOARD OF DENTAL EXAMINERS  
333 Willoughby Avenue, 9th Floor  
P.O. Box 110806  
Juneau, Alaska 99811-0806  
(907) 465-2542 ★ Fax: (907) 465-2974  
E-mail: [license@commerce.state.ak.us](mailto:license@commerce.state.ak.us)

## CERTIFICATION TO ADMINISTER LOCAL ANESTHETIC AGENTS

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No dental hygienist may administer local anesthetic agents without certification from the board. A local anesthetic agent certification is renewed biennially in conjunction with the renewal of the permittee's license to practice dental hygiene in the State of Alaska.

A dental hygienist desiring certification shall apply to the board by either showing successful passing of the local anesthetic examination given by the Western Regional Examining Board (WREB);

OR

Showing documentation that the dental hygienist is currently licensed or certified in another licensing jurisdiction and has actively been administering local anesthetic agents.

### LOCAL ANESTHETIC CERTIFICATION (BY EXAMINATION)

A dental hygienist desiring certification shall apply to the board after registering for and/or successfully passing the local anesthetic examination given by the Western Regional Examining Board (WREB). For information regarding the WREB examination, please contact:

**Western Regional Examining Board**  
9201 North 25<sup>th</sup> Avenue, Suite 185  
Phoenix, AZ 85021  
Telephone: (602) 944-3315  
Fax: (602) 371-8131  
website: [www.wreb.org](http://www.wreb.org)  
E-mail Address: [generalinfo@wreb.org](mailto:generalinfo@wreb.org)

The following documents must be on file before your application will be reviewed for certification to administer local anesthetic agents:

1. Complete, signed and notarized application form;
2. Application fee of \$85.00 (nonrefundable);
3. Certification fee of \$50.00;
4. Completed Course Verification, form 08-0073a, with university or college seal;
5. Course description and/or outline from the university or college where you received your training in administering local anesthetic agents to verify compliance with 12 AAC 28.340;
6. Copy of certificate from the Western Regional Examining Board (WREB) showing successful completion of the local anesthetic portion of the examination; and
7. Copy of both sides of current cardiopulmonary resuscitation (CPR) card.

### LOCAL ANESTHETIC CERTIFICATION (CERTIFIED IN ANOTHER LICENSING JURISDICTION)

1. Complete, signed and notarized application form;
2. Application fee of \$85.00 (nonrefundable);
3. Certificate fee of \$50.00.

4. Completed Course Verification, form 08-0073a, with university or college seal;
5. Course description and/or outline from the university or college where you received your training in administering local anesthetic agents to verify compliance with 12 AAC 28.340;
6. Copy of both sides of current cardiopulmonary resuscitation (CPR) card;
7. Verification of licensure, form 08-0073b, sent directly from a jurisdiction where you hold a license/certificate to administer local anesthetic agents. The license/certificate must be current and in good standing.
8. Verification that you have actively, as part of routine dental hygiene procedure, administered local anesthetic agents at least an average of once per week during the two years immediately preceding the date of application. This verification must come from your employer, form 08-0073c.

## **GENERAL INFORMATION**

When submitting fees, make check or money order payable to the State of Alaska.

## **APPLICATION REVIEW**

Applications will be processed according to the date received. You will be notified in writing as soon as your application has been reviewed.

Applications are processed as quickly as possible. Unnecessary telephone calls to our office delay processing. Because of telephone calls regarding the status of application and because of privacy issues, **we prefer to restrict our telephone responses to the applicant only.** If you are concerned about your application being received in our office, mail it "Certified – Return Receipt Requested." You will receive a delivery notice from the post office. Applications received and complete (including **all** supporting documentation) within two or three weeks of a board meeting will be reviewed at the board meeting; otherwise, completed applications will be sent to the board members using the mail ballot voting process.

The Board of Dental Examiners meets four times a year, usually in March, June, September, and December. The meeting dates are available on the board website at: [www.commerce.state.ak.us/occ/pden.htm](http://www.commerce.state.ak.us/occ/pden.htm). In the event that you do not have access to the Internet, you may contact this office for the meeting dates.

## **RENEWAL INFORMATION**

All certificates expire on December 31 of odd-numbered years, regardless of when issued, except certificates issued within 90 days of the expiration which are issued through the next biennium.

## **ADDRESS CHANGE**

In accordance with 12 AAC 02.900, a person must notify the division, in writing, of a change of address.

## **SOCIAL SECURITY NUMBERS**

AS 08.01.060 and 08.01.100 require that a U.S. Social Security Number be on file with the division before a professional license is issued or renewed for an individual. If you do not have a U.S. Social Security Number, please complete the "Request for Exception from Social Security Number Requirement" form located at [www.commerce.state.ak.us/occ](http://www.commerce.state.ak.us/occ) OR contact the division for a copy of the form.

## **PUBLIC INFORMATION**

Please be aware that all information on the initial application form will be available to the public, unless required to be kept confidential by state or federal law. Information about current licensees, including mailing addresses, is available on the division's website at [www.commerce.state.ak.us/occ](http://www.commerce.state.ak.us/occ) under "Professional License Search."

## **PAYMENT OF CHILD SUPPORT**

Alaska Statute 25.27.244 requires the Division of Corporations, Business and Professional Licensing to deny issuance of the professional and occupational licenses of any person reported by the Alaska Child Support Services Division (CSSD) as not in substantial compliance with a child support order.

If this office is notified by the CSSD that you are not in substantial compliance with a child support order, you may be issued a nonrenewable temporary license valid for 150 days. The 150-day temporary license period is your opportunity to work with CSSD to obtain a release. If you have questions regarding the status of your child support obligation, you may contact CSSD at (907) 269-6657 if your last name begins with A through M; contact (907) 269-6845 if your last name begins with N through Z, or 1-800-478-3300 to resolve payment issues.

## **BOARD NEWSLETTER**

The Board of Dental Examiners newsletter is available for viewing on the board website at: [www.commerce.state.ak.us/occ/pden.htm](http://www.commerce.state.ak.us/occ/pden.htm).

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FOR OFFICE USE ONLY

**APPLICATION FOR CERTIFICATION TO ADMINISTER  
LOCAL ANESTHETIC AGENTS**

NONREFUNDABLE APPLICATION FEE: \$85.00

PERMIT FEE: \$50.00

I hereby apply for certification to administer local anesthetic agents in the State of Alaska, and submit the following statements, under oath, and herewith enclose the required documents and fees.

**INSTRUCTIONS TO THE APPLICANT**

It is the responsibility of the applicant to ensure that all information requested in this application is received. Each question must be answered fully, truthfully, and accurately. Any omissions or inaccuracies are grounds for disapproval and rejection. AS 08.32.160(1) of the Dental Hygiene Practice Act provides that knowingly cooperating in deceit, fraud, or intentional misrepresentation to obtain a license is cause for suspension, revocation, or annulment of licensure. If the space for any answer is insufficient, the applicant may complete his/her answer on another sheet signed by him/her and specifying the number of the question to which it relates.

**Type or print all requested data.**

1. Name in Full: \_\_\_\_\_  
Last First M.I.

Other Name(s) Used: \_\_\_\_\_

2. Mailing Address: \_\_\_\_\_  
\_\_\_\_\_ Zip Code: \_\_\_\_\_

3. Residence Address: \_\_\_\_\_  
\_\_\_\_\_ Zip Code: \_\_\_\_\_

4. Office Address: \_\_\_\_\_  
\_\_\_\_\_ Zip Code: \_\_\_\_\_

5. Daytime Telephone: \_\_\_\_\_ Home Telephone: \_\_\_\_\_

6. SSN.: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex:  Female  Male  
(Required by AS 08.01.060(b))

7. I received the degree of \_\_\_\_\_ from \_\_\_\_\_  
(college or university)  
\_\_\_\_\_ on the \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_.

8. I received my training in administering local anesthetic agents from \_\_\_\_\_ in \_\_\_\_\_  
(college or university)

9. How many years have you devoted to the clinical practice of dental hygiene? \_\_\_\_\_

10. Alaska Dental Hygiene License number and date of issuance: \_\_\_\_\_

11. List other states where you are currently licensed or certified to administer local anesthetic agents. Provide number and date of issuance: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

12. Have you actively, as part of routine dental hygiene procedure, administered local anesthetic agents at least an average of once per week during the two years immediately preceding the date of application?  Yes  No

If you answer "Yes" to the question, the office must receive the Verification of Employment form 08-0073c.

13. Date and location of local anesthetic WREB examination: \_\_\_\_\_

**I HEREBY CERTIFY that the information contained in this application is true and correct to the best of my knowledge. I further certify that all credentials supplied by me are true and correct. I understand that any false information or falsification of credentials may result in failure to obtain a certificate to administer local anesthetic agents in the State of Alaska.**

**I have read the Alaska Dental Hygiene Practice Act. I solemnly declare upon my honor that, if granted certification to administer local anesthetic agents in Alaska, I will respectfully comply with any law governing the administration of local anesthetic agents in this state, and I will do my best to uphold and maintain the ethics of the profession.**

SIGN HERE



\_\_\_\_\_  
Signature of Applicant

SUBSCRIBED AND SWORN before me, a Notary Public, in and for the State of \_\_\_\_\_  
this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

\_\_\_\_\_  
Notary Public

SEAL

My Commission Expires: \_\_\_\_\_

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## COURSE VERIFICATION

**TO WHOM IT MAY CONCERN:**

I am applying for certification to allow me to administer local anesthetic agents in the State of Alaska. The Board of Dental Examiners requires that this form be completed by the institution where I received my training in administering local anesthetic agents. Please complete this form and attach a course description and/or course outline of local anesthetic course and return it directly to the address above.

I hereby release all academic records necessary to complete the following questionnaire to the Board of Dental Examiners.

\_\_\_\_\_  
Name as Given on Diploma

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Other Name(s) Used (if applicable)

\_\_\_\_\_  
Date of Graduation

Name of Institution: \_\_\_\_\_

Address: \_\_\_\_\_

Course Title: \_\_\_\_\_

Course Content: Please check the appropriate box that applies to the course that the applicant attended:

- |                                                                                                                                                                                                                                                                                                           | YES                      | NO                       |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|
| 1. at least 16 clock hours of classroom lecture .....                                                                                                                                                                                                                                                     | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. at least eight clock hours of laboratory instruction during which time three injections each of the anterior palatine, incisive palatine, anterior and middle superior alveolar, posterior superior alveolar, inferior alveolar, mental, long buccal and infiltration injections are administered..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. clinical experience sufficient to establish the hygienist's ability to adequately anesthetize the entire dentition and supporting structures in a clinical setting, requiring not less than six clock hours, under the direct supervision of course faculty. ....                                      | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Instruction in                                                                                                                                                                                                                                                                                         |                          |                          |
| A. medical history evaluation procedures .....                                                                                                                                                                                                                                                            | <input type="checkbox"/> | <input type="checkbox"/> |
| B. anatomy of the head, neck, and oral cavity as it relates to administering local anesthetic agents .....                                                                                                                                                                                                | <input type="checkbox"/> | <input type="checkbox"/> |
| C. pharmacology of local anesthetic agents, vasoconstrictors and preservatives, including physiologic actions, types of anesthetics, and maximum dose per weight .....                                                                                                                                    | <input type="checkbox"/> | <input type="checkbox"/> |

|                                                                                                                                                                                                                                                                                                                                                                                                 | YES                      | NO                       |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|
| D. systemic conditions which influence selection and administration of anesthetic agents .....                                                                                                                                                                                                                                                                                                  | <input type="checkbox"/> | <input type="checkbox"/> |
| E. signs and symptoms of reactions to local anesthetic agents, including monitoring of vital signs .....                                                                                                                                                                                                                                                                                        | <input type="checkbox"/> | <input type="checkbox"/> |
| F. management of reactions to, or complications associated with, the administration of local anesthetic agents to include .....                                                                                                                                                                                                                                                                 | <input type="checkbox"/> | <input type="checkbox"/> |
| (i) a currently valid cardiopulmonary resuscitation certification card from either the American Heart Association or the American Red Cross; or a provision for instruction and certification in cardiopulmonary resuscitation from an instructor certified in cardiopulmonary resuscitation by the American Heart Association or the American Red Cross as part of the course curriculum ..... | <input type="checkbox"/> | <input type="checkbox"/> |
| G. selection and preparation of the amamentaria for administering various local anesthetic agents .....                                                                                                                                                                                                                                                                                         | <input type="checkbox"/> | <input type="checkbox"/> |
| H. methods of administering local anesthetic agents with emphasis on                                                                                                                                                                                                                                                                                                                            |                          |                          |
| (i) technique .....                                                                                                                                                                                                                                                                                                                                                                             | <input type="checkbox"/> | <input type="checkbox"/> |
| (ii) aspiration .....                                                                                                                                                                                                                                                                                                                                                                           | <input type="checkbox"/> | <input type="checkbox"/> |
| (iii) slow injection .....                                                                                                                                                                                                                                                                                                                                                                      | <input type="checkbox"/> | <input type="checkbox"/> |
| (iv) minimum effective dosage.....                                                                                                                                                                                                                                                                                                                                                              | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. instruction by a faculty member of the college or university presenting the course .....                                                                                                                                                                                                                                                                                                     | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. procedures for determining whether the hygienist has acquired the necessary knowledge and proficiency to administer local anesthetic agents.....                                                                                                                                                                                                                                             | <input type="checkbox"/> | <input type="checkbox"/> |

**➡ Attach a course description and/or course outline of local anesthetic course. ⬅**

I HEREBY CERTIFY that the above information regarding the training in administering local anesthetic agents that \_\_\_\_\_ completed is true and correct to the best of my knowledge, and that \_\_\_\_\_ has acquired the necessary knowledge and proficiency to administer local anesthetic agents.

(University or College Seal)

\_\_\_\_\_  
Signature of Dean

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**VERIFICATION OF LICENSURE**  
*(If applying by licensure/certification in another jurisdiction)*

**TO WHOM IT MAY CONCERN:**

I am applying for a license to administer local anesthetic agents as a dental hygienist in the State of Alaska. The Board of Dental Examiners requires that this form be completed by the jurisdiction in which I hold a current license or certification to administer local anesthetic agents. Please complete the form and return it directly to the Board of Dental Examiners at the above address.

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Date of Birth: \_\_\_\_\_

**PLEASE DO NOT DETACH. The information below must be completed by the state licensing board, and not by the applicant.**

State of \_\_\_\_\_

Name of Licensee \_\_\_\_\_

Graduate of \_\_\_\_\_ Year \_\_\_\_\_

Local Anesthetic License or Certification No. \_\_\_\_\_ issued effective \_\_\_\_\_

License or certification is current \_\_\_\_\_ lapsed \_\_\_\_\_ expiration date \_\_\_\_\_

Has the applicant's license or certification ever been suspended, revoked, voluntarily suspended, placed on probation, or restricted in any other way?  Yes  No

If so, for what reason? \_\_\_\_\_  
\_\_\_\_\_

Derogatory information, if any \_\_\_\_\_

Comments, if any \_\_\_\_\_

Signed: \_\_\_\_\_

Contact Telephone No.: \_\_\_\_\_

Title: \_\_\_\_\_

State Board: \_\_\_\_\_

Date: \_\_\_\_\_

(BOARD SEAL)  
(All verifications must have board seal.)

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**VERIFICATION OF EMPLOYMENT**  
*(If applying by licensure/certification in another jurisdiction)*

**TO WHOM IT MAY CONCERN:**

I, \_\_\_\_\_, am applying for a certification to administer local anesthetic agents as a dental hygienist in the State of Alaska.

This form must be completed by the supervising dentist(s) for the Dental Hygienist named above. The dentist(s) must verify that the dental hygienist has been actively, as part of routine dental hygiene procedure, administered local anesthetic agents at least an average of once per week during the two years immediately preceding the date of application for a certification to administer local anesthetic agents. Please complete this form and return it directly to the Board of Dental Examiners at the above address.

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This certifies that \_\_\_\_\_ administered local  
(Applicant)  
anesthetic agents in the State of \_\_\_\_\_ and that \_\_\_\_\_  
has been administering local anesthetic agents for me as part of routine dental hygiene procedures at least an average of once  
per week during the two years from \_\_\_\_\_ to \_\_\_\_\_.  
(Month/Day/Year) (Month/Day/Year)

I attest that he/she is worthy of receiving a certification to administer local anesthetic agents in the State of Alaska.

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Signature of Dentist

\_\_\_\_\_  
License Number

\_\_\_\_\_  
Daytime Phone Number

Address: \_\_\_\_\_  
\_\_\_\_\_

SUBSCRIBED AND SWORN TO BEFORE me this \_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_\_.

\_\_\_\_\_  
Notary Public

Notary Public in and for State of \_\_\_\_\_

My Commission Expires \_\_\_\_\_