IOWA | Department of Inspections, Appeals, & Licensing

Certification of Local Anesthesia Administration

Please provide the information requested below concerning your administration of local anesthesia. Return the completed form to IDB@Iowa.gov.

Applicant Information

Name: _____ **Email Address**: _____

I hereby certify that I have maintained my skills in the administration of local anesthesia, and the information contained in this form is accurate.

Signature: _____ **Date**: _____

Summary of Local Anesthesia Administration

Name of Supervising Dentist: _____ **License #**: _____

Street Address: _____

City, State, Zip: _____ **Phone #**: _____

Dates of Administration (from): _____ (to): _____

Name of Supervising Dentist: _____ **License #**: _____

Street Address: _____

City, State, Zip: _____ **Phone #**: _____

Dates of Administration (from): _____ (to): _____

Name of Supervising Dentist: _____ **License #**: _____

Street Address: _____

City, State, Zip: _____ **Phone #**: _____

Dates of Administration (from): _____ (to): _____

Dept. Inspections, Appeals, & Licensing
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