



CHESTER J. CULVER
GOVERNOR

PATTY JUDGE
LT. GOVERNOR

IOWA DENTAL BOARD
CONSTANCE L. PRICE, EXECUTIVE DIRECTOR

DENTAL HYGIENISTS:

REQUIREMENTS TO ADMINISTER LOCAL ANESTHESIA

Iowa Administrative Code 650 – 11.7(147,153) authorizes a dental hygienist to administer local anesthesia provided the following requirements are met:

1. The dental hygienist holds both an active dental hygiene license and local anesthesia permit issued by the Iowa Dental Board.
2. The local anesthesia is prescribed by a licensed dentist.
3. The local anesthesia is administered under the direct supervision of the dentist. Direct supervision requires the supervising dentist to be present in the treatment facility, but it is not required that the dentist be physically present in the treatment room.

If you wish to administer local anesthesia in Iowa, you must meet the above requirements and make application for a local anesthesia permit. Obtaining your dental hygiene license does not automatically qualify you to administer local anesthesia. The application for a local anesthesia permit requires the following:

1. A completed application form including the application fee of \$70.
2. Evidence that formal training in the administration of local anesthesia has been completed within 12 months of the date of application. The formal training must be conducted by a school accredited by the American Dental Association Commission on Dental Accreditation; or
3. If you currently practice local anesthesia out of state, you must submit evidence of completion of formal training in the administration of local anesthesia conducted by a school accredited by the American Dental Association Commission on Dental Accreditation and submit documented evidence of ongoing practice in the administration of local anesthesia.

If you should have any questions concerning this application, approved courses, or the requirements, please contact the board office at 515-281-5157.

APPLICATION FOR LOCAL ANESTHESIA PERMIT

IOWA DENTAL BOARD

400 S.W. 8th Street, Suite D, Des Moines, Iowa 50309-4687

Ph. (515) 281-5157 <http://www.dentalboard.iowa.gov>

If you are applying for a local anesthesia permit, the following forms must be completed in their entirety.
The application fee is \$70.

1. IDENTIFYING INFORMATION

| | | | |
|--|---------|---------------------|------------|
| Full Legal Name: (Last, First, Middle, Suffix) | | | |
| Other Names Used: (e.g. Maiden) | | | |
| Home Address: | | | Telephone: |
| City: | County: | State: | Zip: |
| Work Address: | | | Telephone: |
| City: | County: | State: | Zip: |
| Home Email Address: | | Work Email Address: | |

2. DENTAL HYGIENE EDUCATION

| | |
|--------------------------------|---------------------|
| Name of Dental Hygiene School: | |
| Address: | Date of Graduation: |

3. LOCAL ANESTHESIA TRAINING

| | | | |
|--------------|---|-------------------|--------------|
| Institution: | Type of Training Received: | From (Mo, Yr): | To (Mo, Yr): |
| | <input type="checkbox"/> Undergraduate <input type="checkbox"/> Post-graduate | | |
| Address: | City: | State/Providence: | |

Do you currently administer local anesthesia in another state? Yes No

If yes, please submit the Certification of Local Anesthesia Administration in addition to the Certification of Local Anesthesia Training.

Please provide the name of the current dentist(s) who will be supervising your administration of local anesthesia, if applicable. **Current employer:** _____

STATEMENT OF APPLICANT

I hereby certify that the above statements are true and correct to the best of my knowledge.

Signature of Applicant: _____ Date: _____

Signature of Notary Public: _____ Date: _____

Notary Seal

| | | | | | | |
|-------------|-----------|--------------|-----------------|------|-----------------|---------------|
| Office Use: | Permit #: | Date Issued: | Iowa DH Lic. #: | Fee: | Cert. Training: | Cert. Admin.: |
|-------------|-----------|--------------|-----------------|------|-----------------|---------------|

CERTIFICATION OF LOCAL ANESTHESIA TRAINING

As part of the permit application process, the Iowa Dental Board requires that the institution at which the applicant received her/his local anesthesia training complete this form. The completed form must be mailed directly to the **IOWA DENTAL BOARD**. Any processing fees are the applicant's responsibility.

Print Name _____

Signature _____ **Date** _____

This portion of the form should be completed by the course instructor.

IT IS HEREBY CERTIFIED THAT _____
(Name of Applicant)

COMPLETED A COURSE IN LOCAL ANESTHESIA AT _____
(Name of School)

LOCATED AT _____
(Full Address of School)

THE TRAINING WAS COMPLETED ON _____.
(Date)

Was the school accredited by the Commission on Dental Accreditation of the American Dental Association at the time the training was completed? Yes No

This course included a clinical component requiring demonstration of clinical competence in delivery of maxillary and mandibular injections. Yes No

Signature of Course Instructor: _____

Title: _____

Address: _____

Telephone: _____ Fax: _____

Type or Print Name: _____

Return Completed Form to:
IOWA DENTAL BOARD
400 S.W. 8th St, Suite D
Des Moines, IA 50309-4687
Phone (515) 281-5157

CERTIFICATION OF LOCAL ANESTHESIA ADMINISTRATION

STATEMENT OF MAINTAINING LOCAL ANESTHESIA SKILLS

Please provide the information requested below concerning your administration of local anesthesia.

| | |
|---|-------------|
| Name of Supervising Dentist: | |
| Address: | |
| License Number: | Phone: |
| Dates of Local Anesthesia Administration: From (mo/yr): | To (mo/yr): |

| | |
|---|-------------|
| Name of Supervising Dentist: | |
| Address: | |
| License Number: | Phone: |
| Dates of Local Anesthesia Administration: From (mo/yr): | To (mo/yr): |

| | |
|---|-------------|
| Name of Supervising Dentist: | |
| Address: | |
| License Number: | Phone: |
| Dates of Local Anesthesia Administration: From (mo/yr): | To (mo/yr): |

| | |
|---|-------------|
| Name of Supervising Dentist: | |
| Address: | |
| License Number: | Phone: |
| Dates of Local Anesthesia Administration: From (mo/yr): | To (mo/yr): |

I hereby certify that I have maintained my skills in the administration of local anesthesia.

Signature: _____ Date: _____

Return Completed Form to:
IOWA DENTAL BOARD
400 S.W. 8th St, Suite D
Des Moines, IA 50309-4687
Phone (515) 281-5157
Fax: (515) 281-7969