

# MISSISSIPPI STATE BOARD OF DENTAL EXAMINERS

Suite 200 • 715 S. Pear Orchard Road • Ridgeland, MS • 39157 • 601-944-9622 • www.dentalboard.ms.gov

**TO:** DENTAL HYGIENIST  
**FROM:** Denny Hydrick, Executive Director  
**SUBJECT:** Application To Administer Local Anesthesia

**Updated: June 2024**

Thank you for your application to administer local anesthesia. The following are the items required for application for Certification to Administer Local Anesthesia in the State of Mississippi.

All questions must be answered fully, truthfully, and accurately. If a question does not pertain to you, indicate by typing "N/A" in the space provided. The Board encourages you to provide as much detail as possible. All requested supporting documentation must be received by the Board prior to the issuing of a Certificate. Items required:

1. You will be asked to provide the information regarding your completed course in Administration of Local Anesthesia.
2. You will be asked to provide information on what teaching modalities were utilized in the course. For example: didactic instruction only; clinical instruction only; both didactic and clinical instruction.
3. You will be asked to describe the scope of local anesthesia techniques covered in the course.
4. You will be required to provide the date that you successfully passed the CDCA-WREB-CITA administered examination covering Administration of Local Anesthesia.
5. You will be asked to acknowledge that you understand that you must still practice under the direct supervision of a Mississippi Licensed dentist, pursuant to Miss. Code Ann. § 73-9-5.
6. A \$50 Initial Application fee will be required. Renewal of the certification will occur on a biennial basis concurrent with your dental hygiene license renewal. The biennial fee for renewal will be \$25.00.

Application over 90 days without payment or submission of the required items will be rejected and not processed.

## **APPLICATION CHECKLIST**

- Application form completed
- Education: transcript evidencing successful completion of a course in Administration of Local Anesthesia as part of ADA CODA accredited program OR certificate evidencing successful completion of a course in Administration of Local Anesthesia affiliated with our offered through an ADA CODA-accredited program as a stand-alone continuing education offering.
- Verification of Course Content: The course must include both didactic and clinical components. The course covered both block and infiltration techniques.
- CDCA-WREB-CITA Examination in Administration of Local Anesthesia.
- \$50 Initial Application fee

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APPLICATION FOR CERTIFICATION TO ADMINISTER LOCAL ANESTHESIA

I hereby make application for issuance of a Certification in the State of Mississippi to administer local anesthesia, all in accordance with and subject to the rules and regulations of the Mississippi State Board of Dental Examiners and the laws governing the practice of dentistry in the State of Mississippi.

First Name Middle Maiden Name Last Name

YOUR NAME AS YOU WOULD LIKE IT TO APPEAR ON YOUR MISSISSIPPI CERTIFICATE

Mississippi Dental Hygienist License Number Email

Current Residence Address (STREET ONLY) City State Zip Code

Current Office Address (STREET ONLY) City State Zip Code

Current Mailing Address (STREET OR POST OFFICE) City State Zip Code

Home: Number Cell

Office: Telephone Number Office: Fax

PROFESSIONAL INFORMATION

1. Do you currently hold a Mississippi Dental Hygienist License? Yes No

2. Please provide:

Name of Course taken to Administer Local Anesthesia:

Location of Course:

Was the Course affiliated with an ADA CODA- accredited Program? Yes No

Date the course was completed:

3. What teaching modalities were utilized in the course?

Didactic instruction only

Clinical instruction only

Both Didactic and Clinical instruction

Other, please provide details:

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4. What was the scope of local anesthesia techniques covered in the course?

- Infiltration technique only
  - Block technique only
  - Both Infiltration and Block techniques
  - Other, please specify: \_\_\_\_\_
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5. Please provide the date you successfully passed the CDCA-WREB-CITA-administered examination covering Administration of Local Anesthesia: \_\_\_\_\_

**NOTE:** Applicants must have a certified transcript or certificate evidencing successful completion of course in Administration of Local Anesthesia as part of ADA CODA-accredited program or stand-alone continuing education offering. Proof of completion must be presented to this Board prior to a certification/permit being issued.

**ACKNOWLEDGMENT**

6. In addition to the foregoing, I add the following:

- (a) I understand that, even if the Board issues me a Certification to Administer Local Anesthesia, I must still practice under the direct supervision of a Mississippi licensed dentist, pursuant to Miss. Code Ann. § 73-9-5.
- (b) I hereby grant permission to the Mississippi State Board of Dental Examiners to secure additional information concerning me or any statement in this Application from any person or any source the Board may desire. Additionally, I understand that the Board will post on its Internet web site all information it deems necessary to enable the public to verify my licensure status. I further agree to submit to questioning by the Board or any member thereof, and to substantiate my statements if desired by the Board.
- (c) I, \_\_\_\_\_, the applicant herein, depose and say that all facts, statements, and answers contained in this Application are true and correct; I am not omitting any information which might be of value to this Board in determining my qualifications and character, whether it is called for or not; and I agree that any falsification, omission, or withholding of information or facts concerning my qualifications as an applicant shall be sufficient to bar me from certification in Mississippi, and such falsifications, omissions, or withholding shall serve as sufficient grounds for the suspension, cancellation, or revocation of my Mississippi Dental Hygienist License even though it is not discovered until after issuance.

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

Signature: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

SWORN TO AND SUBSCRIBED BEFORE ME on this the  
\_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_

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

SEAL

State: \_\_\_\_\_ County: \_\_\_\_\_

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