



**ARKANSAS STATE BOARD
OF DENTAL EXAMINERS**

101 East Capitol Avenue, Suite 111

Little Rock, AR 72201

Phone: 501-682-2085 | Email: asbde@arkansas.gov

FOR BOARD USE ONLY

Permit # _____

Date Issued _____

APPLICATION FOR A LOCAL ANESTHESIA PERMIT

Please print or type.

Name:
Home Address:
City, State, Zip:
Home Phone:

Arkansas License #:	Date Issued:
Where course taken:	
When course taken:	

Employer:	Lic. #:
Office Address:	
City, State, Zip:	
Office Phone:	

With this application, enclose the following:

- Proof of successful completion of a local anesthesia course sponsored by or held in an ADA accredited dental hygiene/dental school. This proof must be either a copy of a certificate from the sponsor showing course dates, your name, and transcript from the school with an official school seal affixed, or an original letter from the school. On the transcript, please highlight or circle the anesthesia course.
- Copy of current certificate of basic life support CPR.
- Application fee of \$1.00.

Signature of Applicant

Date