STATE OF TENNESSEE
DEPARTMENT OF HEALTH
DIVISION OF HEALTH LICENSURE AND REGULATION
OFFICE OF HEALTH RELATED BOARDS
665 MAINSTREAM DRIVE
NASHVILLE, TENNESSEE 37243

TENNESSEE BOARD OF DENTISTRY
(615) 532-3202 or 1-800-778-4123
https://www.tn.gov/health/health-program-areas/health-professional-boards/dentistry-board.html

Certification of Successful Completion of the Injections Required for the Administration of Local Anesthesia Certification

The dental hygienist must complete all injections within ninety (90) days of issuance of the temporary permit after completion of a board approved administration of local anesthesia course. If the dental hygienist is employed by more than one dentist, then each dentist who supervised injections must initial the form for the types of injections that they supervised the dental hygienist successfully performing.

Dental Hygienist's Name: _____ License #: _____

Employer Dentist(s):

Name: _____

Address: _____

City: _____ , TN

Zip Code: _____ Phone: _____

Name: _____

Address: _____

City: _____ , TN

Zip Code: _____ Phone: _____

Identify the patient (by initials) and the date when each of the following injections was performed. The supervising dentist(s) must confirm successful completions by initialing in the appropriate location.

Posterior Superior Alveolar			
	Date	Patient Initials	Successful Injection (Doctor's Initials)
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			

Inferior Alveolar Block			
	Date	Patient Initials	Successful Injection (Doctor's Initials)
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			

Dental Hygienist's Name: _____ License #: _____

Middle Superior Alveolar			
	Date	Patient Initials	Successful Injection (Doctor's Initials)
1.			
2.			

Anterior Superior Alveolar			
	Date	Patient Initials	Successful Injection (Doctor's Initials)
1.			
2.			

Nasopalatine			
	Date	Patient Initials	Successful Injection (Doctor's Initials)
1.			
2.			

Greater Palatine			
	Date	Patient Initials	Successful Injection (Doctor's Initials)
1.			
2.			

Long Buccal			
	Date	Patient Initials	Successful Injection (Doctor's Initials)
1.			
2.			

Mental Block			
	Date	Patient Initials	Successful Injection (Doctor's Initials)
1.			
2.			

Lingual Block			
	Date	Patient Initials	Successful Injection (Doctor's Initials)
1.			
2.			

I, _____ _____ hereby certify that
Name of 1st Employer Dentist *License Number*

the above information is true and correct and that all injections noted above were successfully completed between

_____ and _____.
(Date of first successful injection) *(Date of last successful injection)*

_____ _____
Signature of 1st Employer Dentist *Date*

I, _____ _____ hereby certify that
Name of 2nd Employer Dentist *License Number*

the above information is true and correct and that all injections noted above were successfully completed between

_____ and _____.
(Date of first successful injection) *(Date of last successful injection)*

_____ _____
Signature of 2nd Employer Dentist *Date*