DO NOT WRITE IN THE SPACE BELOW – FOR OFFICE USE ONLY		
Approved: _____	Issue Date: _____	Expiration Date: _____

APPLICATION FOR LICENSURE TO PRACTICE EXPANDED FUNCTIONS IN THE STATE OF WYOMING

WYOMING BOARD OF DENTAL EXAMINERS
1800 Carey Avenue 4th Floor
Cheyenne, WY 82002
(307) 777-7387

Please type or print neatly.

INSTRUCTIONS TO APPLICANT: Please return your application with proof of a course taken in expanded functions as well as a current CPR certificate.

1. Name: _____
   Last First Middle Initial Previous Names Used

2. Social Security: _____ Date of Birth: _____

3. Home Address: _____ Telephone Number: ( )

4. Business Address: _____ Telephone Number: ( )

5. Preferred Mailing Address: ☐ Home ☐ Business

6. Are you applying for: Local Anesthesia ___ Yes ___ No Nitrous Oxide Analgesia ___ Yes ___ No

7. Course of formal training you have taken: _____

8. University or College: _____

9. Date the Course was taken: _____

_____
SIGNATURE OF APPLICANT