BUREAU OF PROFESSIONAL

AND OCCUPATIONAL AFFAIRS

VERIFICATION OF OPIOID EDUCATION

APPLICANT INFORMATION

NAME:	Last	First	Middle
OTHER NAME(S):			
DATE OF BIRTH :		**LAST 4 DIGITS OF SSN:**	
ADDRESS:			
CITY / STATE / ZIP:			

BOARD-APPROVED CE PROVIDER INFORMATION

NAME OF PROGRAM/PROVIDER:	
ADDRESS:	
CITY, STATE, ZIP:	
PHONE NUMBER:	
PRINT NAME OF DIRECTOR / PROVIDER:	
EMAIL ADDRESS OF DIRECTOR / PROVIDER:	

The following information must be completed by the Director of the Program or the Board-approved continuing education provider and must verify that the applicant successfully completed at least 2 hours of education in pain management or the identification of addiction and 2 hours of education in the practices of prescribing or dispensing of opioids.

I hereby certify that the above listed applicant successfully completed 2 hours of education in pain management or the identification of addiction and 2 hours of education in the practices of prescribing or dispensing of opioids on

_____ _____ _____

Month Day Year

I verify that the above statements are true and correct as validated by my review of the applicant's records. I verify that the information communicated on this form is true and correct to the best of my knowledge, information and belief. I understand that any false statement made is subject to the penalties of 18 Pa. C.S. §4904, relating to unsworn falsification to authorities.

Original Signature Director / Provider:		Date:	Month	Day	Year

RETURN THIS FORM TO:

STATE BOARD OF DENTISTRY
PO BOX 2649
HARRISBURG, PA 17105