WellCare Health Plans

Fluoride Varnish Application Attestation Form

Physician Name: ______________________________ **Provider ID #:** ______________
Street Address: ____
City: ______________________ **State:** **New Jersey** **ZIP Code:** ______________
Phone: ______________________ **Email:** ______________________

Fluoride Varnish Attestation

Training: Training for the topical application of fluoride varnish can be obtained through a link on the WellCare Provider Portal or directly at the Smiles for Life website provided below.

Credit to Dr. Joanna Douglass and the Smiles for Life National Oral Health Curriculum – Fluoride Varnish Module

- Smiles for Life (click Quick Link Course 6, "Caries Risk Assessment, Fluoride Varnish & Counseling," at: **http://www.smilesforlifeoralhealth.org.**

Please attest to the appropriate statements below by printing your name on the respective lines.

I, ______________________, have completed the Caries Risk Assessment, Fluoride Varnish & Counseling training course and assessment on the Smiles for Life National Oral Health Curriculum website. I have the proper knowledge and understanding to administer applications of fluoride varnish to WellCare Health Plans, Inc., members under the age of 6.

I, ______________________, have completed the Caries Risk Assessment, Fluoride Varnish & Counseling training course and assessment on the Smiles for Life National Oral Health Curriculum website, and I have trained the following medical staff in my office on the application of fluoride varnish to WellCare Health Plans, Inc., members through the age of 6.

Fax your completed Fluoride Varnish Application Attestation Form to **1-813-865-6759.**

______________________________ ______________
Physician Signature: Date Signed:

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Certificate Date:

Personnel Trained on Caries Risk Assessment, Fluoride Varnish & Counseling

Print Name:	**Signature:**
Print Name:	**Signature:**

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