FOR OFFICE USE ONLY

Dental Hygienist Checklist
- ☐ DH App & Fee ($65.00)
- ☐ Photograph
- ☐ Birth Certificate
- ☐ License Verification
- ☐ DH Transcript
- ☐ National Boards
- ☐ Regional Boards/State Exam

Local Anesthesia Permit
- ☐ Local Anesthesia App & Fee ($70.00)
- ☐ Local Anesthesia NERB Results
- ☐ Local Anesthesia Transcript
- ☐ CPR/Basic Life Certification

Nitrous Oxide Permit
- ☐ Nitrous Oxide App & Fee ($70.00)
- ☐ Nitrous Oxide Nerb Results
- ☐ Nitrous Oxide Transcript
- ☐ CPR/Basic Life Certification

*****FOR OFFICE USE ONLY*****

Receipt #

ID #

Issue Date

License #

Rhode Island
Board of Examiners in Dentistry

Room 205
3 Capitol Hill
Providence, RI 02908-5097

License #_____

Name_____

Instructions and License Application for:

☐ Dental Hygienist

☐ Local Anesthesia Permit

☐ Nitrous Oxide Permit

☐ **Endorsement** ☐ **Examination**

Applicant - Print Name (First/MI/Last)

Phone: (401) 222-2837 **TTY/TDD: (800) 745-5555** **Fax: (401) 222-2158**

Revised 08/13/2012 jcp

GENERAL INFORMATION

Enclosures

The following materials and information should be enclosed within this application packet:

Page

Application Process Overview..... 3

Instructions for Completing Board Application..... 4-5

Application Materials:

Board Application..... 6-9
Application Checklist..... 10
Reciprocity Release Form..... 11
Local Anesthesia Permit Application..... 12
Nitrous Oxide Permit Application..... 13

Licensure Requirements

U.S./Canadian Graduates

- License Fee(s) of **$65.00** for Dental Hygienist and **$70.00** for Local Anesthesia Permit, **$70.00** for Local Nitrous Oxide Permit - TOTAL of **$205.00 for all three.**

- Graduated from a dental hygiene school accredited by the American Dental Association Commission on Dental Accreditation.

- Satisfactorily passed licensure examinations approved by the Board.

- Meet any other requirement(s) set forth by regulation or established by the Board.

Rules and Regulations

To obtain the Rules and Regulations for your profession visit the A-Z list on the Topics & Programs page at the following web site. From the list click on the letter for your profession.

http://www.health.ri.gov/atoz/

Rhode Island General Laws pertaining to the Practice of Dentistry can be obtained at the following web sites:

Dental Licensure **http://www.rilin.state.ri.us/statutes/title5/5-31.1/index.htm**

APPLICATION PROCESS OVERVIEW

The licensure process in the State of Rhode Island is conducted by the Rhode Island Board of Examiners in Dentistry (Board). All licensure applicants must complete and submit a Board application.

Application Process

You must submit your application and supporting credentials directly to the Board. The Board will use this information to assess your qualifications for licensure. Please allow a minimum of 4 weeks for the entire licensure process to be completed. If you have malpractice or disciplinary history, it can take an additional 2 or 3 months for all pertinent documentation to be received.

Only applications which are complete, with all supporting credentials, will be considered and approved for licensure. Licenses will be issued within 7-10 working days following approval of the Department and are mailed to the address furnished in your application. You are responsible for notifying the Board office, in writing, if your address changes in the interim. Visit the following website to obtain a change of address form.

http://www.health.ri.gov/forms/changeofaddress/professions.pdf

To obtain your license number prior to receiving your license card, please refer to the HEALTH Licensee Lookup web site (Approximately ten (10) days after Board Meeting):

https://healthri.mylicense.com/Verification/

HEALTH will not, for any reason, accelerate the processing of one applicant at the expense of others. Once completed, the application will be reviewed, and you will be contacted in writing.

Please continue to review the remaining portions of this application packet for instructions and other materials necessary to complete the Board application. If you have any questions about this application process, or would like to check on the status of your Board application, please contact this office at (401) 222-2837.

INSTRUCTIONS FOR COMPLETING THE BOARD APPLICATION

Read the following instructions and those throughout the application packet carefully before completing the Board application. Failure to submit all required information and appropriate documentation may result in processing delays. All of the information provided is subject to change.

General Instructions

1. Make a copy of the application and forms before you begin, in case you make a mistake.

2. Type your information or print in blue or black ball-point pen. Board staff will not make assumptions about illegible information. Be sure to print your name in the box provided on the cover page.

3. Provide a response to each section or question; otherwise, mark "N/A" for Not Applicable.

4. We suggest that you make a copy of your completed application before submitting it to the Board.

5. **It is your responsibility to check on the status of your application.**

Completing your Application

1. Complete the Application pages (6-9). Complete the Local Anesthesia Permit on Page 12 and the Nirous Oxide Permit on Page 13 (if applicable). You must respond to all components of the application as instructed. If you attach separate pages in continuation of the Board application, such pages MUST clearly indicate the section for which such information is being reported.

2. Make a check or money order (in U.S. Funds only) for the application fee of **$65.00** for Dental Hygienist, **$70.00** for Local Anesthesia Permit **$70.00** for Nitrous Oxide Permit or **$205.00 for all three** payable to "Rhode Island General Treasurer" and staple it to the upper left-hand corner of the first (Top) page of the application. These application fees are **NON-REFUNDABLE.** Please be advised that this is an application fee and includes the first license **only** up until the next expiration date. All Dental Hygienists licenses and permits expire biennally on June 30th of the even numbered years.

Complete all application materials as instructed and arrange them in order as they appear in the application checklist (see page 10). Do not submit applications without all applicable information, documentation and fee. Mail these components of the application to:

Rhode Island Department of Health
Board of Examiners in Dentistry, Room 205
3 Capitol Hill
Providence, RI 02908-5097

Dental Hygienist-Initiated Requests

In addition to the materials you mail to the Board, you must also mail information to other sources for verification. Follow these additional steps as described below:

1. Obtain licensure verification from all states where you hold, or have ever held, a license to practice dental hygiene. To obtain this verification, you must mail the Reciprocity Release Form (page 11) to each licensing authority in which you are/were licensed. If you are licensed in Canada, send a copy to each province in which you are/were licensed. Type your information or print in blue or black ball-point pen. Board staff will not make assumptions about illegible information.

2. Be certain to sign and complete the identifying information on each form. T**he Board must receive the verification(s) directly from the licensing authority**. Make copies of the form as needed. You may obtain

the mailing addresses of all U.S. dental boards and licensing authorities may be obtained at the **American Association of Dental Examiners (AADE)** web site at:

http://www.aadexam.org

or by calling the Board in question. Please do not contact the Rhode Island Board of Examiners in Dentistry for mailing addresses of licensing authorities.

3. Official Dental Hygiene School transcript must be submitted directly to this office by the Dental Hygiene School.

4. Official Copy of the National Board Scores must be submitted directly to this office by the **American Dental Association (ADA)** (312) 440-2500.

5. Official results of the NERB Examination(s)

6. Regional or state Board examination results (if applicable).

7. A certified copy of your Birth Certificate (Notarized photo copies are acceptable), If born outside the U.S., proof of citizenship or lawful alien status.

The application process is not considered complete until your Board application, applicable forms and credentials are received in a manner satisfactory to the Board. The Board will not accelerate processing of one applicant at the expense of others for any reason. Once completed, your application will be reviewed and you will be contacted in writing. Be advised that you may be required to appear for an interview. Please allow 7-10 working days following approval of your application for your wallet size license card to be mailed to you. [**NOTE:** You may not practice dental hygiene nor administer Local Anesthesia or Nitrous Oxide in Rhode Island until you have received a license number.]

State of Rhode Island
Board of Examiners in Dentistry

Application for License to Practice Dental Hygiene

Refer to the Application Instructions when completing these forms. Type or block print only. Do not use felt-tip pens.

1. Name(s)

This is the name that will be printed on your License/Permit/ Certificate and reported to those who inquire about your License/ Permit/ Certificate. Do not use nicknames, etc.

Title (i.e., Mr., Mrs., Ms., etc.)

First Name

Middle Name

Surname, (Last Name)

Suffix (i.e., Jr., Sr., II, III)

Degree

Maiden, if applicable

Name(s) under which originally licensed in another state, if different from above (First, Middle, Last).

2. Social Security Number

U.S. Social Security Number

"Pursuant to Title 5, Chapter 76, of the Rhode Island General Laws, as amended, I attest that I have filed all applicable tax returns and paid all taxes owed to the State of Rhode Island, and I understand that my Social Security Number (SSN) will be transmitted to the Divison of Taxation to verify that no taxes are owed to the State."

3. Gender

☐ Male ☐ Female

4. Date of Birth

Month Day Year 19

5. Home Address

It is your responsibility to notify the board of all address changes.

1st Line Address (Apartment/Suite/Room Number, etc.)

Second Line Address (Number and Street)

City

State

Zip Code

Country, If NOT U.S.

Postal Code, If NOT U.S.

Home Phone

Home Fax

Email Address (Format for email address is Username@domain e.g. applicant@isp.com)

6. Primary Business Address

It is your responsibility to notify the board of all address changes.

This address will appear on the Department of Health web site.

Name of Business/Work Location

1st Line Address (Department/Suite/Room Number, etc.)

Second Line Address (Number and Street)

City

State

Zip Code

Country, If NOT U.S.

Postal Code, If NOT U.S.

Business Phone

Extension

Business Fax

7. Preferred Mailing Address

Please check ONE

☐ Please use my **Home Address** as my preferred mailing address

☐ Please use my **Business Address** as my preferred mailing address

8. Practice History

Please provide your practice history for the last five (5) years.

Month	Year		Month	Year	Name and Location of Facility: NOTE: You may continue information on a separate sheet of paper.
		—			
		—			
		—			
		—			
		—			
		—			
		—			
		—			
		—			
		—			
		—			

9. Qualifying Education

Please list the name and information about the school that you attended that qualifies you for this license.

Type of School (University, College, etc.)

Name of School

Date Graduated Month Year

Is school accredited by the American Dental Association (ADA)? ☐ Yes ☐ No

Degree Conferred

10. Regional or State Board Examination

Please indicate the type, name and date of your examination

☐ Regional ☐ State

Name of Examination

Date Completed Month Year

Passed? ☐ Yes ☐ No

11. National Board Examination

Date Completed Month Year

Passed? ☐ Yes ☐ No

12. Dental Hygiene Licensure

List all states or countries in which you are now, or ever have been licensed to practice dentistal hygiene, or any other profession.

State/Country:			State/Country:		
	☐ Active	☐ Inactive		☐ Active	☐ Inactive
	☐ Active	☐ Inactive		☐ Active	☐ Inactive
	☐ Active	☐ Inactive		☐ Active	☐ Inactive
	☐ Active	☐ Inactive		☐ Active	☐ Inactive

DOCUMENTATION: Send a Reciprocity Release Form to each entity. *(See page 13)*

13. Board Discipline

List any disciplinary actions by licensing boards in other states. Please describe any prior or pending Board action or investigation. Please attach any relevant supplemental materials. If necessary, you may continue on a separate 8 1/2 X 11 sheet of paper.

☐ Check here if not applicable.

Licensing Board (abbreviate) and Nature of Action (e.g. TX - Professional Misconduct):	Month	Year	Type of Discipline:

Please describe any prior or pending Board action or investigation. Please attach any relevant supplemental materials.

14. Criminal Convictions

Respond to the question at the top of the section, then list any criminal conviction(s) in the space provided.

If necessary, you may continue on a separate 8 1/2 X 11 sheet of paper.

Have you ever been convicted of a violation, plead Nolo Contendere, or entered a plea bargain to any federal, state or local statute, regulation, or ordinance or are any formal charges pending; including use of illicit substances or operating a motor vehicle while intoxicated. (Please include any offenses which have been expunged from your record)? ☐ Yes ☐ No

Abbreviation of State and Conviction[1] (e.g. CA - Illegal Possession of a Controlled Substance):

	Month	Year

[1]For purposes of this section, a person shall be deemed to be convicted of a crime if he/she plead guilty or if he/she was found or adjudged guilty by a court of competent jurisdiction or has been convicted of a felony by the entry of Nolo Contendere in any state.

15. Disciplinary Questions

Check either Yes or No for each question.

1. Has any Health Professional license, certificate, registration, or permit you hold or have held, been disciplined or are any formal charges pending? ☐ Yes ☐ No

2. Have you ever been denied a license, certificate, registration or permit in any state? ☐ Yes ☐ No

Note: If you answer "Yes" to any question, you are **required** to furnish complete details, including date, place, reason and disposition of the matter. You may use the space below or, if needed, on a separate sheet of paper.

16. Affidavit of Applicant

Complete this section and sign in the presence of a notary public.

Make sure that you and the notary public have completed all components accurately and completely.

I, _____, being first duly sworn, depose and say that I am the person referred to in the foregoing application and supporting documents.

I hereby authorize all hospital(s), institution(s) or organizations(s), my references, personal physicians, employers (past and present) and all governmental agencies and instrumentalities (local, state, federal or foreign) to release to the Rhode Island Board of Examiners in Dentistry any information which is material to my application for licensure.

I have read carefully both the statute (RIGL 5-31.1) and associated Regulations (R5-31.1 Reg.) for the licensure of dentists in Rhode Island. Further, I have read carefully the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I knowingly furnish any false information in this application, I hereby agree that such act shall constitute cause for denial, suspension or revocation of my license to practice dental hygiene in the State of Rhode Island.

I understand that this is a continuing application and that I have an affirmative duty to inform the Rhode Island Board of Examiners in Dentistry of any change in the answers to these questions after this application and this affidavit is signed.

_____ Signature of Applicant

_____ Date of Signature (MM/DD/YY)

The foregoing instrument was acknowledged before me this _____ day of

_____, 20_____, by _____,

who is personally known to me or has produced _____

as documentation and did / did not take an oath.

_____ Name of Notary (Print, Type or Stamp)

_____ Signature of Notary

Notary Seal

_____ Notary No/Commission No.

_____ Commission Expiration Date (MM/DD/YY)

17. Recent Photograph

Securely tape or glue in this square a current 2" x 2" photograph of yourself (alone).

Photographs must be recent, passport type photo, clear, front view, full face without a hat or dark glasses.

Full length photos will not be accepted.

Affix Photo Here

Write your name on the back of the photograph, and provide the date that the photograph was taken.

_____ Date of Photograph

APPLICATION CHECKLIST

Please review the following checklist to ensure you have satisfied all components of the application process. Some items may not apply.

Board Application

- [ ] I have read and understand the "Instructions for Completing the Board Application."
- [ ] I have carefully read RIGL 5-31.1 and R5-31.1REG.
- [ ] I have completed the Rhode Island Board application as instructed (pages 6-9).
- [ ] I have completed Section 16, "**Affidavit of Applicant**" and had the form notarized by a notary public.
- [ ] I have attached a photograph to Section 17, "**Recent Photograph**" as instructed. I have verified that it meets the photograph requirements as stated in the application.
- [ ] I have a **check or money order** made payable (in U.S. funds only) to the "**Rhode Island General Treasurer**" in the amount of **$65.00** for Dental Hygienist (ADD **$70.00** for local anesthesia permit, and/or ADD **$70.00** for nitrous oxide permit applicable, for a **total of $205.00 for all three**) and attached have it to the upper left-hand corner of the first (cover/top) page of the application.
- [ ] I have arranged my Board Application materials in following order:

    1. Fee (attached as instructed)
    2. Board Application (cover/top page, and pages 6-9)
    3. Supporting documentation as required. [Note: Pages containing additional information in continuation of the Board application MUST indicate the section for which the information is being reported.]
    4. Local anesthesia permit and/or nitroux oxide permit (if applicable) (p. 12 and p. 13)

- [ ] I have mailed the above application materials directly to the Licensing Office, Department of Health.

Required Forms / Credentials

- [ ] I have completed and mailed the following forms as instructed:

    1. Reciprocity Release Form(s) (Licensure Verification) (page 11)

- [ ] I have requested the following credentials be submitted directly to the BOARD:

    1. Official Dental Hygiene School Transcript
    2. Official copy of National Board Scores
    3. Official Regional or State Board Examination Results
    4. Official results of the NERB Examination(s) (if applicable)
    5. Official transcript from Local Anesthesia Program and/or Nitrous Oxide Program (if applicable)
    6. Proof of current certification in Basic Life and CPR at the "Health Care Provider" level

Substitute forms are not acceptable. This form may be duplicated as needed.

Rhode Island Board of Examiners in Dentistry

Room 205, 3 Capitol Hill
Providence, RI 02908-5097
(401) 222-2837

RECIPROCITY RELEASE FORM

I am applying for a license to practice dental hygiene in the State of Rhode Island. The Rhode Island Board of Examiners in Dentistry requires that the following form be completed by the jurisdiction in which I am now or was previously licensed. This constitutes your authority to release all information in your files, favorable or otherwise, directly to the Rhode Island Board of Examiners in Dentistry at the above address.

Print/Type Full Name

Signature _____ Date _____

Previous Names Used

Social Security Number

Date of Birth 19

License Number _____ Date Issued _____

THIS SECTION TO BE COMPLETED BY THE DENTAL BOARD

Basis for issuing License:

☐ ADA National Board ☐ NERB ☐ Other Regional Board ☐ State Exam _____ (State)

If a combination of exams were taken, please list the specific combination:

License Status: ☐ Active ☐ Inactive ☐ Lapsed	**Original Date Issued:**	**Expiration Date:**

Questions:

1. Has this dental hygienist ever been investigated by your Board? ☐ Yes ☐ No
2. Has this dental hygienist incurred any disciplinary proceedings in your state, or is any action pending? ☐ Yes ☐ No
3. Has the applicant's license ever been denied, surrendered, reprimanded, suspended, revoked or placed on probation? ☐ Yes ☐ No
4. Do you know of any information that may discredit this person? ☐ Yes ☐ No

If you answer "Yes" to questions 1-4, please provide a written explanation below, and attach a copy of all supporting documentation (e.g., Board order, complaint, etc.).

_____

_____

_____

Certification:

Signature _____ Date _____

Type or Print Name

Please Affix
Board Seal Here

Title

Full Name and of Licensing Board including State

Please return directly to the Board at the above address. Thank you for your prompt cooperation.

OFFICE OF HEALTH PROFESSIONALS REGULATION
3 CAPITOL HILL, ROOM 205
BOARD OF EXAMINERS IN DENTISTRY
PROVIDENCE, RI 02908-5097
TEL: 401-222-2837/FAX: 401-222-2158

LOCAL ANESTHESIA PERMIT
WWW.HEALTH.RI.GOV

I HEREBY APPLY for a dental hygiene permit to administer local anesthesia in the State of Rhode Island for which I am submitting all the required credentials and proper fee(s) as outlined in the instructions.

PLEASE PRINT

FULL NAME _____
(First) (Middle) (Last) (Maiden)

ADDRESS _____
Street City/Town State Zip Code

TELEPHONE (Home)_____ (Work)_____ (E-Mail)_____

SS# _____ BIRTH DATE_____ GENDER _____

RI Dental Hygiene License Number _____

LOCAL ANESTHESIA PROGRAM _____

Date of Completion _____

Please check all that apply:

☐ I have satisfactorily completed a course in local anesthesia accredited by the Commission on Dental Accreditation of the American Dental Association that meets the following criteria:
a) minimum of twenty didactic hours and twelve clinical hours which includes no less that the following topics;
- i) neurophysiology of pain and pain control
- ii) pharmacology of local anesthetic solutions and drug interactions;
- iii) potential local and systemic complications;
- iv) medical and dental indications and contraindications;
- v) medical and dental history and assessment;
- vi) safe assembly and handling of a syringe
- vii) location of anatomical landmarks associated with local anesthesia;
- viii) injection techniques;
- ix) hands on experience with maxillary and mandibular injections.

☐ I have successful completed a local anesthesia examination administered by the North East Regional Board (NERB).

☐ I have never been involved in any morbidity or mortality secondary to the administration of local anesthesia

☐ I am currently certified in Basic Life and CPR at the "Health Care Provider" level.

****

A F F I D A V I T

The following acknowledgement must be sworn to before a Notary Public or a Justice of the Peace

STATE OF_____ COUNTY OF_____in _____
In said County, on _____ day of _____ A.D. 20____, personally appeared before
Me, _____of _____, Who, after signing the foregoing application in my presence, made oath that the facts stated in said application are true.

_____ *SEAL* _____
Signature of Applicant *Notary Public/Justice of the Peace*
My Commission Expires on _____

OFFICE OF HEALTH PROFESSIONALS REGULATION
3 CAPITOL HILL, ROOM 205
BOARD OF EXAMINERS IN DENTISTRY
PROVIDENCE, RI 02908-5097
TEL: 401-222-2837/FAX: 401-222-2158

NITROUS OXIDE PERMIT
WWW.HEALTH.RI.GOV

I HEREBY APPLY for a dental hygiene permit to administer nitrous oxide in the State of Rhode Island for which I am submitting all the required credentials and proper fee(s) as outlined in the instructions.

PLEASE PRINT

FULL NAME _____
(First) (Middle) (Last) (Maiden)

ADDRESS _____
Street City/Town State Zip Code

TELEPHONE (Home)_____ (Work)_____ (E-Mail)_____

SS# _____ BIRTH DATE_____ GENDER _____

RI Dental Hygiene License Number _____

NITROUS OXIDE PROGRAM _____

Date of Completion _____

Please check all that apply:

☐ I have satisfactorily completed a course in nitrous oxide accredited by the Commission on Dental Accreditation of the American Dental Association that meets the following criteria:
a) minimum of four (4) didactic hours and four (4) clinical hours which includes no less that the following topics;
i) nitrous oxide techniques
ii) pharmacology of nitrous oxide
iii) nitrous oxide analgesia medical emergency and techniques
iv) selection of pain control modalities, if avaliable

☐ I have successful completed a nitrous oxide examination administered by the North East Regional Board (NERB).

☐ I have never been involved in any morbidity or mortality secondary to the administration of nitrous oxide

☐ I am currently certified in Basic Life and CPR at the "Health Care Provider" level.

****

A F F I D A V I T

The following acknowledgement must be sworn to before a Notary Public or a Justice of the Peace

STATE OF_____ COUNTY OF_____in _____
In said County, on _____ day of _____A.D. 20____, personally appeared before
Me, _____of _____, Who, after signing the foregoing application in my presence, made oath that the facts stated in said application are true.

_____ *SEAL* _____
Signature of Applicant *Notary Public/Justice of the Peace*
My Commission Expires on _____