FOR OFFICE USE ONLY
Dental Hygienist Checklist
☐ DH App & Fee ($65.00)
☐ Driver's License/State Issued ID
☐ DH Graduate Transcript
☐ National Board Exam Results
☐ Regional/State Board Exam Results
☐ ADEX Exam Results
Local Anesthesia Permit
☐ Local Anesthesia App & Fee ($70.00)
☐ Local Anesthesia ADEX Results
☐ Local Anesthesia Certificate
☐ CPR/Basic Life Certification
Nitrous Oxide Permit
☐ Nitrous Oxide App & Fee ($70.00)
☐ Nitrous Oxide ADEX Results
☐ Nitrous Oxide Certificate
☐ CPR/Basic Life Certification

FOR OFFICE USE ONLY
Receipt #
ID #
Issue Date
License #

Rhode Island
Board of Examiners in Dentistry

Room 104
3 Capitol Hill
Providence, RI 02908-5097

Instructions and License Application for:

☐ Dental Hygienist

☐ Local Anesthesia Permit

☐ Nitrous Oxide Permit

License # _____

Name _____

☐ **Endorsement** ☐ **Examination**

MILITARY STATUS ELIGIBILITY *(Documentation Required) see next page for instructions*

Please check ONE of the following criteria for expedited application:

☐ I am in active military duty or a reservist
☐ I am a military veteran with honorable discharge
☐ I am the spouse of someone in active military duty or the spouse of a reservist

Applicant - Print Name

LAST NAME	*FIRST NAME*	*MI*

Phone: (401) 222-2828 **TTY/TDD: (800) 745-5555** **Fax: (401) 222-1272**

LICENSURE REQUIREMENTS

Dental Hygienist

- ☐ Completed Application with Cover Page - Applications are valid for 1 year from the day they are received at RIDOH. If you are not licensed within the year you must submit a new application.
- ☐ Check or money order (preferred), made payable (in U.S. funds only) to the RI General Treasurer in the amount of **$65.00** and attached to the upper left-hand corner of the first (Top) page of the application. THE APPLICATION FEES ARE NONREFUNDABLE. Please be advised that this is an application fee and includes the first license **only** up until the next expiration date. All licenses expire biennally on June 30th of the even numbered years.
- ☐ Copy of Driver's License or state issued ID
- ☐ Official Dental Hygiene School Graduate transcript must be submitted directly to this office by the Dental Hygiene School.
- ☐ Official copy of the National Board Scores must be submited directly to this office by the **American Dental Association (ADA)** (312) 440-2500
- ☐ Official Copy of the Regional or state Board examination results
- ☐ If applying for expedited military status you must include one of the following: Leave Earning statement (LES), Letter from Command, Copy of Orders or DD-214 showing honorable discharge.
- ☐ If you have ever been licensed in another state, license verification(s) must be sent directly from the state(s) in which you hold or have held a license. (Interstate Verification Form included in this application can be used for that purpose)

Additional Local Anesthesia Permit and/or Nitrous Oxide Permit - (if applicable)

- ☐ Completed Application(s) - Application forms are included within this application.
- ☐ Check or money order (preferred), made payable (in U.S. funds only) to the RI General Treasurer in the amount **$70.00** for Local Anesthesia Permit and/or **$70.00** for Local Nitrous Oxide Permit
- ☐ Official transcript from Local Anesthesia Program and/or Nitrous Oxide Program
- ☐ Official results of the NERB Examination(s)
- ☐ A current certification in Basic Life Support and CPR at the "Health Care Provider" level.

License Certificates

RIDOH will be providing wallet license cards ONLY on issuance of licenses. If you wish to receive a license certificate, suitable for framing, please check the box below and attach a separate check in the amount of $30.00 made payable to RI General Treasurer.

- ☐ I would like to receive a license certificate. I have enclosed a separate check in the amount of $30.00

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.

Home Addresses are not published information.

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.
		—			
		—			
		—			
		—			
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		—			
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		—			
		—			

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

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, pled 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.

16. Affidavit of Applicant

I, _____ affirm that the information provided on this application form and the documentation provided to support this application is true, accurate complete, and unaltered. I acknowledge that, pursuant to RIGL 11-18-1, knowingly making a false statement on this application form is punishable as a misdemeanor, and that such an act shall constitute cause for denial, suspension, or revocation of my license/ permit 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)

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

19 Date of Birth

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

Title

Full Name and of Licensing Board including State

Please Affix
Board Seal Here

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

RHODE iSLAND DEPARTMENT OF HEALTH
CENTER FOR PROFESSIONAL LICENSING
3 CAPITOL HILL, ROOM 104
BOARD OF EXAMINERS IN DENTISTRY
PROVIDENCE, RI 02908-5097
TEL: 401-222-2828

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 19____ 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 ADEX
☐ I am providing a copy of my local anesthesia program certificate
☐ I am providing a copy of my valid Basic Life and CPR "Health Care Provider Level" certification
☐ I attest that I have never been involved in any morbidity or mortality secondary to the administration of local anesthesia

****

AFFIDAVIT

I, _____, affirm that the information provided on this application form and the documentation provided to support this application is true, accurate complete, and unaltered. I acknowledge that, pursuant to RIGL 11-18-1, knowingly making a false statement on this application form is punishable as a misdemeanor, and that such an act shall constitute cause for denial, suspension, or revocation of my license/permit 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)

RI DEPARTMENT OF HEALTH
CENTER FOR PROFESSIONAL LICENSING
3 CAPITOL HILL, ROOM 104
BOARD OF EXAMINERS IN DENTISTRY
PROVIDENCE, RI 02908-5097
TEL: 401-222-2828

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 19 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 ADEX
☐ I am providing a copy of my nitrous oxide program certificate
☐ I am providing a copy of my valid Basic Life and CPR "Health Care Provider Level" certification
☐ I attest that I have never been involved in any morbidity or mortality secondary to the administration of nitrous oxide

****

AFFIDAVIT

I, _____, affirm that the information provided on this application form and the documentation provided to support this application is true, accurate complete, and unaltered. I acknowledge that, pursuant to RIGL 11-18-1, knowingly making a false statement on this application form is punishable as a misdemeanor, and that such an act shall constitute cause for denial, suspension, or revocation of my license/permit 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)