FOR OFFICE USE ONLY
Public Health Dental Hygienist Checklist

- ☐ App & Fee ($65.00)
- ☐ Valid Photo ID
- ☐ Work and/or clinical experience
- ☐ CEU Requirements

Out of State

- ☐ Official Transcript
- ☐ National Board Exam results
- ☐ ADEX exam results
- ☐ Verification from other state(s)

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:

Public Health Dental Hygienist

RI Dental Hygienist License #____________________

Applicant - Print License Number

License #________

Name________

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

- [ ] Completed, Notarized 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. THIS APPLICATION FEE IS NONREFUNDABLE. Please be advised that this is an application fee and includes the first license **only** up until the next expiration date. All Dental Hygiene licenses expire biennally on June 30th of the even numbered years.
- [ ] Valid license as a dental hygienist in the State of Rhode Island.
- [ ] Supporting official documentation of a minimum of three (3) years full time work as a Registered Dental Hygienist or completion of at least four thousand five hundred (4500) hours of clinical experience.
- [ ] Supporting documentation of completion of a minimum of twelve (12) hours of continuing education in which six (6) hours are hands on experience in a public health setting as defined in the Rules and Regulations Pertaining to Dentists, Dental Hygienists, and Dental Assistants.
- [ ] If applying for expedited military status, please complete the Military Expedition Form at the end of this application packet.

In addition to above (Out of State Candidates Only)

- [ ] Copy of a valid U.S. Driver's license
- [ ] National Board Exam Results be submitted directly to the licensing office.
- [ ] ADEX exam results be submitted directly to the licensing office.
- [ ] Official Dental Hygiene School Graduate transcript must be submitted directly to this office by the Dental Hygiene School.
- [ ] 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)

Licensure Information

Please visit the RIDOH website at **http://www.health.ri.gov/licenses** to Verify your license, download Rules and Regualtions/Laws for your profession, download change of address forms, other licensing forms or obtain our contact information. HEALTH will not, for any reason, accelerate the processing of one applicant at the ex pense of others.

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 A Public Health Dental Hygienist License

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

Please select from the dropdown.

4. Date of Birth

Month

Day

Year 1 9

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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9. Qualifying Education

Please list the name and information about the school that you attended that qualifies you for your **dental hygiene** 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 for your Dental Hygiene license.

☐ 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 dential 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 as a Public Health Dental Hygienist in the State of Rhode Island.

I affirm that I have entered into or will enter into a Written Collaborative Agreement (WCA), prior to practicing as a Public Health Dental Hygienist in accordance with section 2.9.3 of the Rules and Regulations Pertaining to Dentists, Dental Hygienists, and Dental Assistants.

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 104, 3 Capitol Hill
Providence, RI 02908-5097
(401) 222-2828

RECIPROCITY RELEASE FORM

I am applying for a license to practice as a Public Health Dental Hygienist 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 ____________

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 applicant ever been investigated by your Board? ☐ Yes ☐ No
2. Has this applicant 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 return directly to the Board at the above address. Thank you for your prompt cooperation.

Rhode Island Department of Health
Military Expedition Form

Please attach this form to the *front* of your completed application and mail to the address shown on the application cover.

Pursuant to Rhode Island General Laws § 5-88-1 et seq., upon application, this state may recognize occupational licenses, certificates or permits obtained from other states for military members and their spouses who relocate to this state pursuant to military orders. The Rhode Island Department of Health (RIDOH) will expedite your or your spouse's health professional license application provided the following conditions are met.

I. PROFESSION/LICENSE TYPE

Please indicate the profession and/or license type you are applying for so that your application can be routed to the correct office:

Profession/License Type: ____

II. MILITARY STATUS

Please check ONE of the following criteria for expedition:

I am in active military duty or a reservist.

I am the spouse of someone in active military duty or the spouse of a reservist.

I am a military veteran with honorable discharge. *You do not need to complete the rest of this application – please skip to the signature line.*

III. PROOF OF MILITARY STATUS

Please attach a copy of proof of your military status such as one of the following: Leave Earning Statement (LES), Letter from Command, or Copy of Orders

IV. MILITARY CHANGE OF STATION ORDER

Permanent Change of Station Order

V. PROOF OF GOOD STANDING

Proof of good standing from the board in the other state in which the person has a license.

VI. Criminal Background Check (a "BCI") *(unless required in the initial license application)*

BCI completed from the RI Attorney General's Office.

VII. ATTESTATIONS:

Check all that apply:

No board in any other state has revoked the license for which I am applying as a result of negligence or intentional misconduct.

I have never surrendered an occupational license, certificate, or permit because of negligence or intentional misconduct.

I do not have a complaint, allegation, or investigation currently pending before a board in another state which relates to unprofessional conduct or an alleged crime.

I attest that the above responses and information are true and accurate to the best of my knowledge and that none of the information set forth above is false, erroneous, or defective in any important, as set forth in R.I. Gen. Laws § 11-18-1. I understand that this application is being made to the Rhode Island Department of Health, which shall rely upon my attestation and the information provided in this document.

____

Signature of Applicant Date

On a case-by-case basis RIDOH may grant a temporary license should the military member or spouse need additional time to complete education, training, and/or experience for the licensure in Rhode Island. RIDOH will contact the applicant directly should that be needed.