Nevada State Board of Dental Examiners
6010 S. Rainbow Blvd., Bldg. A, Ste. 1
Las Vegas, NV 89118
(702) 486-7044 • (800) DDS-EXAM • Fax (702) 486-7046

PROVIDER APPROVAL APPLICATION: INJECTION OF NEUROMODULATORS, DERMAL AND SOFT TISSUE FILLERS CERTIFICATION PROGRAM

SUBMISSION GUIDELINES

Program Criteria Requirements:
At least 24 hours in length (4 hours didactic + 4 hours hands on instruction) in each of the following three specific subjects:

1) Use of neuromodulators that are derived from clostridium botulinum or that is biosimilar to or the bioequivalent of such a neuromodulator in the treatment of temporomandibular joint disease and myofascial pain syndrome.
2) Use of neuromodulators that are derived from clostridium botulinum or that is biosimilar to or the bioequivalent of such neuromodulator for dental and facial esthetics.
3) Use of dermal and soft tissue filler for dental and facial esthetics.

Location of hands on instruction must be conducted at a registered facility

Program(s) granted Board approval will be conducted as education programs and meet the following minimum requirements:

1) That instruction shall be conducted on the same educational standards of scholarship and teaching as that required of a true university discipline.
2) The course or topic of instruction shall conform to the purpose and method of higher education.

The Nevada State Board of Dental Examiners reserves the right to monitor any and all programs being conducted by an approved provider.

Each approved provider **must** furnish a certificate of completion to all Nevada dental licensees who complete this program.

FEE (FOR "FOR PROFIT" ORGANIZATIONS): $150.00 FOR THE FIRST CREDIT HOUR REQUESTED, $50.00 FOR EACH ADDITIONAL CREDIT HOUR. **THIS FEE IS FOR THE PROCESSING AND REVIEW OF YOUR REQUEST FOR PROVIDER APPROVAL AND MUST ACCOMPANY THIS FORM UPON SUBMISSION OF THE REQUEST.**

ALL PROVIDER APPROVAL REQUESTS MUST BE SUBMITTED TO THE BOARD FOR REVIEW NO LATER THAN 45 DAYS PRIOR TO THE BEGINNING DATE OF THE PROGRAM.

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Instructor(s) Name:

Program Title and Objectives [Must relate directly to the practice of dentistry]:

Number of Participants:
Hours of Actual Instruction:
Registered Facility Name and Address

Date(s) of Program:
Entity Submitting Request:
Business Address:
City, State & Zip:
Business Telephone:
Date of Request:

Signature of Person Authorized to Represent Program

PLEASE ATTACH NAME(S) AND CURRICULUM VITAE(S) FOR EACH INSTRUCTOR, THE OUTLINE OF COURSE (including method of presentation), AND A LETTER SIGNED BY THE PERSON(S) WHO HOLD PROPRIETARY RIGHTS TO THE PROGRAM GRANTING THE BOARD PERMISSION TO REVIEW THEIR PROGRAM.

FOR OFFICE USE ONLY - DO NOT WRITE BELOW THIS LINE.

Approved by:

Number of Hours Approved:
Effective Date of Approval:
Disapproved [Explanation]: