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

OFFICE USE ONLY	
Date Received:	
Payment Amount:	
Staff Initials:	

BIENNIAL ACTIVE DENTAL LICENSE RENEWAL – JULY 1, 2017 – JUNE 30, 2019

READ THIS FORM CAREFULLY

RENEWAL OF YOUR NEVADA DENTAL LICENSE IS COMPLETE UPON THE BOARD'S PHYSICALL RECEIPT OF ALL REQUIRED INFORMATION NO LATER THAN JUNE 30, 2017: INCOMPLETE RENEWAL APPLICATIONS WILL BE RETURNED.

FOR ACTIVE LICENSE RENEWAL: Complete this form with all questions answered and affidavit signed; Renewal fee in the appropriate amount and attest to current CPR certification dates and required number of continuing education hours.	**$600**

Last:	***First:***	***Middle:***	***License Number:***

Pursuant to NAC 631.150, all licensees are required to keep the Board informed of their current address(es). Changes to any address must be reported to the Board office in writing (or updated online) within thirty days of such change. All addresses are treated individually.

IF YOU HAVE MORE THAN ONE OFFICE, PLEASE LIST ANY OTHERS ON A SEPARATE SHEET INCLUDING LICENSED DENTIST NAME.

Name/Practice Name/DBA:		***Office Address:***		
City:	***State:***	***Zip Code:***	***Office Telephone:***	***Office Fax:***

Email:

☐ Select if the Practice Address is your mailing address

Home Address:		***Email:***		
City:	***State:***	***Zip Code:***	***Home Telephone:***	***Home Fax:***

☐ Select if the Home Address is your mailing address

REPORT OF EXISTENCE OF NEVADA BUSINESS LICENSE – NRS 622.240

All licensees **MUST** complete this section, regardless of license status. Please select **One** option:

IF YOU HAVE MORE THAN ONE, PLEASE LIST ANY ADDITIONAL BUSINESS LICENSES ON A SEPARATE SHEET INCLUDING BUSINESS LICENSE NUMBER, STREET ADDRESS, CITY, STATE AND ZIPCODE.

☐ I do **NOT** have a Nevada business license number.

☐ I have applied for a Nevada business license with the Nevada Secretary of State upon compliance with the provision of NRS Chapter 76 and my application is pending.

☐ I have a Nevada business license number assigned by the Nevada Secretary of State upon compliance with the provisions of NRS Chapter 76.

Business license number:	***Street Address:***	***City:***	***State:***	***Zip Code:***

The Nevada State Board of Dental Examiners is not the arbiter of determining whether a licensee needs a business license. Information about the Nevada business license can be found on the Secretary of State's website at: http://nvsos.gov/.

REPORT OF MILITARY SERVICE

Have you ever served in the military? ***(if yes, you must answer the questions below)*** **Yes** ☐ **No** ☐

Date of Service: ***From:*** ***to***	***Military Occupation Specialty/Specialties:***

BRANCH OF SERVICE

Army/Army Reserve	☐	Marine Corps/Marine corps Reserve	☐	Navy/Navy Reserve	☐
Air Force/ Air Force Reserve	☐	Coast Guard/Coast Guard Reserve	☐	National Guard	☐

IF YOU HAVE SERVED MORE THAN ONE MILITARY BRANCH OF SERVICE, PLEASE LIST ANY MILITARY SERVICE ON A SEPARATE SHEET INCLUDING DATE OF SERVICE, MILITARY OCCUPATION SPECIALTY/SPECIALTIES AND BRANCH OF SERVICE.

CONTINUING EDUCATION

NRS 631.342 requires all licensees fulfill a mandated four (4) hour continuing education course in "terrorism" to be completed within two (2) years after receiving licensure in this state. The state mandated course is in addition to your required CE hours. If certificate is not on file with the Board you must provide a copy of the certificate of attendance to receive credit for this "terrorism" course.

☐ **By selecting this box, I hereby affirm and attest that I have completed the required hours of continuing education with recognized providers. I understand that all continuing education certificates of completion issued by recognized providers must be maintained for a minimum of three years and may be audited by the Board pursuant to NAC 631.177. In addition to the required CE hours, pursuant to NRS 631.342. I affirm that I have fulfilled a mandated four (4) hour continuing education course in "terrorism" to be completed two (2) years after receiving licensure in this state.**

CPR CERTIFICATION

New CPR dates: **Begin:** _____ **End:** _____

☐ **By selecting this box, I hereby affirm and attest that I have inserted valid dates of CPR certification on this form for a course taken with an actual administration demonstration by me that was not completed online. I understand that all certifications for CPR issued by certified instructors must be maintained for a minimum of three years and may be audited by the Board pursuant to NAC 631.177.**

DENTAL AUXILIARIES

(Dental Assistants, Radiographic Techs and/or Sterilization Personnel)

Do you employ dental auxiliaries? **No** ☐ ***If no, Please select reason for not having any dental auxiliaries and move to next section.***

Independent Contractor ☐ Instructor ☐ Out of State/Country ☐ I Provide these services ☐ Employee of Practice ☐

Yes ☐ ***If yes, Please answer question (a) and attest check box.***

(a) I certify that each person listed below, is so employed as a dental auxiliary.

Employee Name:	*Type of auxiliary:*	*Date began assisting:*
Employee Name:	*Type of auxiliary:*	*Date began assisting:*
Employee Name:	*Type of auxiliary:*	*Date began assisting:*

☐ **By selecting this box, I attest that each such employee has received:**
(1) Adequate instruction concerning radiographic procedures and is qualified to operate radiographic equipment as required pursuant to subsection 3 of NAC 459.552;
(2) Training in CPR at least every 2 years while so employed;
(3) A minimum of 4 hours of continuing education in infection control every 2 years while so employed; and
(4) Before beginning such employment, a copy of chapter 631 of NAC and chapter 631 of NRS in paper or electronic format.

ANESTHESIA RENEWAL: Only Applicable to Current Permit Holders

FOR EACH PERMIT ISSUED – Each *Administrator Permit* and *Site Permit* are $200 each (biennial).
Include the appropriate permit renewal fee. Overpaid fees cannot be refunded. Underpaid fees necessitate return of renewal.

Administrator Permit – Select permit *($200 each)*

☐ Conscious Sedation ☐ General Anesthesia Current Permit Number:_____	*New ACLS dates:* to	*New PALS dates:* to

☐ I attest that I have completed the required completion of a 3-hour continuing education every 2 years related to anesthesia or sedation – applicable to the type of permit you hold pursuant to NAC 631.2256. I understand that all continuing education certificates of completion issued by recognized providers must be maintained for a minimum of three years and be audited by the Board pursuant to NAC 631.177.

Site Permits – Enter permit number you wish to renew *($200 each)*

Current Site Permit Number:	Current Site Permit Number:
Current Site Permit Number:	Current Site Permit Number:
Current Site Permit Number:	Current Site Permit Number:
Current Site Permit Number:	Current Site Permit Number:

AFFIDAVIT

I hereby certify the following to the Nevada State Board of Dental Examiners for the period of July 1, 2015 – June 30, 2017:

1.	I attest by checking "yes", that I am in compliance with the reporting requirements regarding service of claims or complaints of malpractice, felony or misdemeanor convictions or the suspension, revocation or probation of my license by another licensing jurisdiction pursuant to NAC 631.155. (If no, please provide a written statement outlining the facts.	**Yes** ☐	**No** ☐		
2.	Are you subject to court order for the support of one or more children (i.e. do you have a child support order?)? ***(If yes, you MUST answer question (a) below):***	**Yes** ☐	**No** ☐		
	(a) Are you in compliance with the court order or a plan approved by the District Attorney or other public agency enforcing the order for the payment or the amount owed pursuant to the court order for the support of one or more children? ***(IF YOU ARE NOT IN COMPLIANCE, YOU MUST PROVIDE WRITTEN NOTIFICATION)***	**Yes** ☐	**No** ☐		
3.	Have you conducted practice within the provisions of NRS 631 and NAC 631?	**Yes** ☐	**No** ☐		
4.	Do you have a history of addiction(s) which would impair your practice of dentistry/dental hygiene pursuant to NRS 631 and NAC 631?	**Yes** ☐	**No** ☐		
5.	Do you utilize laser radiation in the performance of your practice of dentistry/dental hygiene? ***(If yes, you MUST answer question (a) below):***	**Yes** ☐	**No** ☐		
	(a) Have you submitted appropriate certification to the Board pursuant to NAC 631.033 and NAC 631.035?	**Yes** ☐	**No** ☐		
6.	I attest by checking "yes", I am aware of the mandatory requirement to report child abuse and neglect in accordance with the laws of the State of Nevada.	**Yes** ☐	**No** ☐		
7.	Do you have a valid controlled substance permit with the Nevada State Board of Pharmacy? ***(If yes, you MUST answer question (a) below):***	**Yes** ☐	**No** ☐		
	(a) Have you conducted a minimum of one self-query annually:	**Yes** ☐	**No** ☐		

Date 1st report ran:_____ Date 2nd report ran: _____ DEA Number:_____

☐ **By Selecting this box, I hereby affirm and attest, that I have answered the above questions truthfully, accurately, and by me personally, the licensee so named on this form and so stating, under penalties of perjury, that all answers provided herein are provided willfully. I further state that I authorize and empower the Nevada State Board of Dental Examiners or its agents, staff, or appointed authority to contact any person, firm, service, agency, entity, or the like to obtain information deemed necessary or desirable by the Board to verify any information contained in my license renewal application and affidavit.**

Licensee Signature: _____ ***Date:*** _____

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RENEWAL PAYMENT FORM

CREDIT CARD AUTHORIZATION

RENEWAL FEES MAY BE PAID BY VISA, MASTERCARD, DISCOVER CARD, CHECK, OR MONEY ORDER.

FOR PAYMENT BY CREDIT CARD, PLEASE COMPLETE THE FOLLOWING:

CHARGE RENEWAL FEE OF $: _____ ***TO***

PLEASE CIRCLE ONE: **VISA** **MASTERCARD** **DISCOVER CARD**

CREDIT CARD NUMBER: _____ ***EXP DATE:*** _____

NAME ON CARD: _____ ***SECURITY CODE:*** _____

BILLING ADDRESS FOR CREDIT CARD: _____

_____

_____

SIGNATURE: _____

FOR PAYMENT BY CHECK / MONEY ORDER, MAKE PAYABLE TO: **NEVADA STATE BOARD OF DENTAL EXAMINERS**

INCLUDE ALL FEES