



Nevada State Board of Dental Examiners

2651 N. Green Valley Pkwy, Ste. 104
Henderson, NV 89014
(702) 486-7044 • (800) DDS-EXAM • Fax (702) 486-7046

OFFICE USE ONLY

Date Received: _____

Payment Amount: _____

Staff Initials: _____

DENTAL LIMITED LICENSE RENEWAL – July 1, 2024 – June 30, 2025

READ THIS FORM CAREFULLY

YOUR NEVADA DENTAL LIMITED LICENSE RENEWAL IS COMPLETE UPON THE BOARD'S PHYSICAL RECEIPT OF ALL REQUIRED INFORMATION NO LATER THAN JUNE 30, 2024. INCOMPLETE RENEWAL APPLICATIONS WILL BE RETURNED.

FOR DENTAL LIMITED LICENSE RENEWAL: Complete this form with all questions answered, affidavit signed, renewal fee in the appropriate amount, and attest to current CPR certification dates and required number of continuing education hours.
(NAC 631.029)

\$200

Last:	First:	Middle:	License Number:
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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:
<input type="checkbox"/> Select if the Practice Address is your mailing address				
Home Address:		Email:		
City:	State:	Zip Code:	Home Telephone:	Cell Phone:
<input type="checkbox"/> 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 ZIP CODE.

<input type="checkbox"/> I do NOT have a Nevada business license number.				
<input type="checkbox"/> 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.				
<input type="checkbox"/> I have a Nevada business license number assigned by the Nevada Secretary of State upon compliance with the provisions of NRS Chapter 76.				
Name of Business:				
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/>.

CPR CERTIFICATION

New CPR dates:	Begin:	MM / YYYY	End:	MM / YYYY
<input type="checkbox"/>	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.			

REPORT OF MILITARY SERVICE

Have you ever served in the military? <i>(If yes, you must answer the questions below)</i>		Yes <input type="checkbox"/> No <input type="checkbox"/>
Date of Service: From: MM/DD/YYYY to MM/DD/YYYY		Military Occupation Specialty/Specialties:
BRANCH OF SERVICE		
Army/Army Reserve <input type="checkbox"/>	Marine Corps/Marine corps Reserve <input type="checkbox"/>	Navy/Navy Reserve <input type="checkbox"/>
Air Force/ Air Force Reserve <input type="checkbox"/>	Coast Guard/Coast Guard Reserve <input type="checkbox"/>	National Guard <input type="checkbox"/>
IF YOU HAVE SERVED IN MORE THAN ONE MILITARY BRANCH OF SERVICE, PLEASE LIST ADDITIONAL MILITARY SERVICE ON A SEPARATE SHEET INCLUDING DATE OF SERVICE, MILITARY OCCUPATION SPECIALTY/SPECIALTIES AND BRANCH OF SERVICE.		
Have you ever served on active duty in the Armed Forces of the United State and separated from such service under conditions other than dishonorable?		Yes <input type="checkbox"/> No <input type="checkbox"/>
Have you ever been assigned to duty for a minimum of 6 continuous years in the National Guard or a reserve component of the Armed Forces of the United States and separated from such service under conditions other than dishonorable?		Yes <input type="checkbox"/> No <input type="checkbox"/>
Have you ever served the Commissioned Corps of the United States Public Health Service or the Commissioned Corps of the National Oceanic and Atmospheric Administration of the United States in the capacity of a commissioned officer while on active duty in defense of the United States and separated from such service under conditions other than dishonorable?		Yes <input type="checkbox"/> No <input type="checkbox"/>

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.

DENTAL AUXILIARIES

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

Do you employ dental auxiliaries?		No <input type="checkbox"/> <i>If no, please select reason for not having any dental auxiliaries and move to next section.</i>
Independent Contractor <input type="checkbox"/>	Instructor <input type="checkbox"/>	Out of State/Country <input type="checkbox"/>
I Provide these services <input type="checkbox"/>		Employee of Practice <input type="checkbox"/>
Yes <input type="checkbox"/> <i>If yes, Please answer question (a) and attest check box.</i>		
(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:		
<input type="checkbox"/> (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 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 ADMINISTRATOR PERMIT RENEWAL: Only Applicable to Current Permit Holders

FOR EACH PERMIT ISSUED – Each Administrator Permit is \$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)			
<input type="checkbox"/> Moderate Sedation (13 Years or Older) Permit Number(s): _____ <i>New ACLS dates:</i> MM / YYYY to MM / YYYY	<input type="checkbox"/> Moderate Sedation (12 Years or Younger) Permit Number(s): _____ <i>New PALS dates:</i> MM / YYYY to MM / YYYY	<input type="checkbox"/> Pediatric Moderate Sedation Permit Number(s): _____ <i>New PALS dates:</i> MM / YYYY to MM / YYYY	<input type="checkbox"/> General Anesthesia Permit Number(s): _____ <i>New ACLS dates:</i> MM / YYYY to MM / YYYY
<input type="checkbox"/> I attest that I have completed the required completion of a 6-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.			

ANESTHESIA SITE PERMIT RENEWAL: Only Applicable to Current Site Permit Holders

FOR EACH PERMIT ISSUED – Each Site Permit is \$200 each (biennial).

Include the appropriate permit renewal fee. Overpaid fees cannot be refunded. Underpaid fees necessitate return of renewal.

Site Permits – Enter permit number you wish to renew (\$200 each)			
Site Permit No.:	Site Permit No.:	Site Permit No.:	Site Permit No.:
Site Permit No.:	Site Permit No.:	Site Permit No.:	Site Permit No.:
Site Permit No.:	Site Permit No.:	Site Permit No.:	Site Permit No.:

AFFIDAVIT

I hereby certify the following to the Nevada State Board of Dental Examiners for the period of July 1, 2023 – June 30, 2024:

1.	Have you had any claims or complaints of malpractice filed against you, felony or misdemeanor convictions or the suspension, revocation or probation of a license issued by this agency or another licensing jurisdiction during the period of July 1, 2023, to June 30, 2024? (If yes, please provide a written statement outlining the facts.)	Yes <input type="checkbox"/>		No <input type="checkbox"/>
2.	Are you subject to court order for the support of one or more children (i.e., do you have a child support order?)? <i>(If yes, you MUST answer question (a) below):</i>	Yes <input type="checkbox"/>		No <input type="checkbox"/>
	(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? <i>(IF YOU ARE NOT IN COMPLIANCE, YOU MUST PROVIDE WRITTEN NOTIFICATION)</i>	Yes <input type="checkbox"/>		No <input type="checkbox"/>
3.	Have you complied with the provisions of NRS 631 and NAC 631 (Nevada Governing Laws)?	Yes <input type="checkbox"/>		No <input type="checkbox"/>
4.	Do you continue to meet all the licensing requirements pursuant to NRS 631.271? You must attach a copy of your current employment contract to this completed renewal form. <i>(If no, you MUST provide a written statement explaining why)</i>	Yes <input type="checkbox"/>		No <input type="checkbox"/>
5.	Do you have any addictions which would impair your practice of dentistry/dental hygiene pursuant to NRS 631 and NAC 631?	Yes <input type="checkbox"/>		No <input type="checkbox"/>
6.	Do you utilize laser radiation in the performance of your practice of dentistry/dental hygiene? <i>(If yes, you MUST answer question (a) below):</i>	Yes <input type="checkbox"/>		No <input type="checkbox"/>
	(a) Have you submitted appropriate certification to the Board pursuant to NAC 631.033 and NAC 631.035?	Yes <input type="checkbox"/>		No <input type="checkbox"/>
7.	Do you inject neuromodulator that is derived from clostridium botulinum, dermal and soft tissue fillers to your patients? <i>(If yes, you MUST answer question (a) below):</i>	Yes <input type="checkbox"/>		No <input type="checkbox"/>
	(a) Have you completed a board approved certification course to inject neuromodulator that is derived from clostridium botulinum, dermal and soft issue fillers? <i>(If yes, you must submit certification documents with renewal)</i>	Yes <input type="checkbox"/>		No <input type="checkbox"/>
8.	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 <input type="checkbox"/>		No <input type="checkbox"/>



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CREDIT CARD AUTHORIZATION FORM

Name of Person Requesting:		Mailing Address (where to mail document requested):	
Telephone Number: () -		_____	
NV License Number:	<input type="checkbox"/> Dental <input type="checkbox"/> Dental Hygiene	Suite No.: _____	City: _____
		State: _____	Zip Code: _____

Dental Licensure Application Fees	
<input type="checkbox"/> License by Exam – WREB (\$1200)	
<input type="checkbox"/> License by Exam – ADEX (\$1200)	
<input type="checkbox"/> License by Endorsement (\$1200)	
<input type="checkbox"/> Specialty License by Credential (\$1200)	
<input type="checkbox"/> Geographically Restricted (\$600)	
<input type="checkbox"/> Limited License – Faculty / Resident (\$125)	
<input type="checkbox"/> Limited Licensed for Supervision (\$100)	
<input type="checkbox"/> Restricted License (\$125)	
<input type="checkbox"/> Military by Reciprocity (\$1200)	
<input type="checkbox"/> Specialty License by App [NV licensed Dentist only] (\$125) <i>(If applying for a general dental license & specialty license concurrently, application fee will be \$1325)</i>	

Dental Hygiene Licensure Application Fees	
<input type="checkbox"/> Licensure by Exam – WREB (\$600)	
<input type="checkbox"/> Licensure by Exam – ADEX (\$600)	
<input type="checkbox"/> Licensure by Endorsement (\$600)	
<input type="checkbox"/> Geographically Restricted (\$150)	
<input type="checkbox"/> Limited License (\$125)	
<input type="checkbox"/> Military by Reciprocity (\$600)	

Dental Hygiene Permit Application Fees	
<input type="checkbox"/> Local Anesthesia Permit (\$25)	
<input type="checkbox"/> Nitrous Oxide Permit (\$25)	

License Renewal Fees	
<input type="checkbox"/> Active Status \$ _____	
<input type="checkbox"/> Inactive Status \$ _____	
<input type="checkbox"/> Retired Status \$ _____	
<input type="checkbox"/> Disabled Status \$ _____	
<input type="checkbox"/> Limited License \$ _____	
<input type="checkbox"/> Restricted License \$ _____	
<input type="checkbox"/> License Reactivation (\$300)	

Dental Anesthesia Permit Fees	
Permit Application: \$ _____ (choose below):	
<input type="checkbox"/> General Anesthesia Administrator Permit (\$750)	
<input type="checkbox"/> Moderate Sedation Administrator Permit (\$750)	
<input type="checkbox"/> Pediatric Moderate Sedation Administrator Permit (\$750)	
<input type="checkbox"/> Site Permit (\$500)	
Renewal: \$ _____ Permit No.: _____	
(choose one): <input type="checkbox"/> General Anesthesia <input type="checkbox"/> Moderate Sedation <input type="checkbox"/> Site Permit	
Permit Re-Inspection: \$ _____	
(choose one): <input type="checkbox"/> Administration Permit Re-inspection (\$500) <input type="checkbox"/> Site Permit Re-inspection (\$350)	

Reinstatement of License Fees	
<input type="checkbox"/> Suspended (\$300) <input type="checkbox"/> Revoked (\$500)	

Request for Duplicate Certificate Fees	
<input type="checkbox"/> Duplicate Wall Certificate (\$25)	
<input type="checkbox"/> Name Change Fee - New Wall Certificate (\$25)	
<input type="checkbox"/> Duplicate DH Local Anesthesia/N2O Permit (\$25)	
<input type="checkbox"/> Duplicate Dental Anesthesia Permit (\$25 each) (Select below):	
<input type="radio"/> GA Admin. Permit No.: _____	
<input type="radio"/> Mod. Sedation Admin. Permit No.: _____	
<input type="radio"/> Peds Mod. Sed Admin. Permit No.: _____	
<input type="radio"/> Site Permit No.: _____	

Infection Control Inspection	
<input type="checkbox"/> Initial Infection Control Inspection (\$250)	

Miscellaneous Fees	
<input type="checkbox"/> NRS Booklet (\$3) x _____	
<input type="checkbox"/> NAC Booklet (\$3) x _____	
<input type="checkbox"/> Returned Check Fee (\$25)	
<input type="checkbox"/> Change of Address Fine (\$50)	
<input type="checkbox"/> Civil Penalty \$ _____	
<input type="checkbox"/> Investigation Costs \$ _____	
<input type="checkbox"/> Continuing Education Provider Fee: (1 st Hour = \$150 / each additional hour = \$50) Total Hours: _____ Total Fee: \$ _____	

Other: _____

Name on Credit Card:	Method of Payment: <input type="checkbox"/> MasterCard <input type="checkbox"/> Visa <input type="checkbox"/> Discover	Total Amount Authorized: \$ _____
Credit Card Billing Address: _____	Credit Card Number: _____ - _____ - _____	
Ste. No.: _____ City: _____ State: _____ Zip Code: _____	Exp. Date: _____ - _____ Security Code: _____	

Purchaser's Signature: _____ Date: ____/____/____

**** THERE IS A 7 to 15 BUSINESS DAY PROCESSING PERIOD FOR ALL REQUESTS****

Form accepted by mail or fax (see the top of the page), or email PDF to nsbde@dental.nv.gov