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

FACT SHEET

APPLICANTS FOR A DENTAL THERAPY LICENSE

Thank you for your interest in applying for a dental therapy license in the State of Nevada. Senate Bill 366 was enacted by the Legislature and became law in July 2019.

ELIGIBILITY REQUIREMENTS

1. A person may be eligible to apply for a license to practice dental therapy in this State who:

(a) Is of good moral character;
(b) Is over 18 years of age;
(c) Is a graduate of a program of dental therapy from an institution which is accredited by a regional educational accrediting organization that is recognized by the United States Department of Education. The program of dental therapy must:
  (1) Be accredited by the Commission of Dental Accreditation of the American Dental Association or its successor specialty accrediting organization; and
  (2) Include a curriculum of not less than 2 years of academic instruction in dental therapy or its academic equivalent; and
(d) Is in possession of a current special health endorsement of his or her license pursuant to NRS 631.287 to practice public health dental hygiene.

2. To determine whether a person has good moral character, the Board may consider whether his or her license to practice dental therapy or dental hygiene in another state has been suspended or revoked or whether he or she is currently involved in any disciplinary action concerning his or her license in that state.

1. Any person desiring to obtain a license to practice dental therapy, after having complied with section 60.2 of this act and the regulations of the Board to determine eligibility:
  (a) Except as otherwise provided in NRS 622.090,must pass a written examination given by the Board upon such subjects as the Board deems necessary for the practice of dental therapy or must present a certificate granted by the Joint Commission on National Dental Examination which contains a notation that the applicant has passed the applicable national examination with a score of 75; and
  (b) Except as otherwise provide in this chapter, must:
    (1) Successfully pass a clinical examination approved by the Board and the American Board of Dental Examiners, or

(2) Present to the Board a certificate granted by the Western Regional Examining Board which contains a notation that the applicant has passed a clinical examination administered by the Western Regional Examining Board.

2. The Board shall examine each applicant in writing on the contents and interpretation of this chapter and the regulations of the Board.
3. All persons who have satisfied the requirements for licensure as a dental therapist must be registered as licensed dental therapists on the board register, as provided in this chapter, and are entitled to receive a certificate of registration, signed by all members of the Board.

The holder of a license or renewal certificate to practice dental therapy may practice only in the settings provided in subsection 3, under the authorization of a dentist meeting the requirements of subsection 4 and in accordance with a written practice agreement signed by the dental therapist and the authorizing dentist. A dental therapist may provide only the services that are within his or her scope of practice, the scope of practice of the dentist, are authorized by the dentist, and are provided according to written protocols or standing orders established by the authorizing dentist. A dental therapist may not provide any services that are outside the scope of practice of the authorizing dentist. A dental therapist shall provide such services only under the direct supervision of the authorizing dentist until such time as the dental therapist has obtained the following hours of clinical practice as a dental therapist:

(a) Not less than 500 hours, if the dental therapist has a license to practice dental therapy issued pursuant to the laws of another state or territory of the United States, or the District of Columbia;

(b) Not less than 1,000 hours, if the dental therapist has practiced dental hygiene pursuant to the laws of this State, another state or territory of the United States, or the District of Columbia, for 5 years or more; or

(c) Not less than 1,500 hours, if paragraphs (a) and (b) are not applicable.

Note: A written practice management agreement is required between the Nevada licensed dentist and the dental therapist.

APPLICATION PROCESS

Jurisprudence Examination/Fingerprints

You will receive written confirmation via US Mail of the receipt of your application and application fee along with the on-line jurisprudence examination username/password and the fingerprint materials within twenty one (21) business days from the date the application is received.

NOTE: Pursuant to the laws of the State of Nevada, you are required to utilize the official fingerprint cards and documents approved by the Nevada Department of Public Safety. The Board is unable to accept any other fingerprint documents. To avoid additional expense, please wait to receive the fingerprint package from the Board.

NOTE: Each applicant shall successfully pass the jurisprudence examination which is based on the contents and interpretation of Chapter 631 and the regulations of the Board. In addition, the applicant must file all required documents to the Board office before an application will be deemed complete and ready for review by the Board's Secretary-Treasurer.

Checklist

The Board has provided you a checklist of the items you will be responsible for requesting and/or submitting to the Board. Please be advised, National Board Scores, Certified Copies of School Transcripts and Verification of Licensure documents if hand delivered must be in sealed envelopes.

Application Review:

Upon receipt of all required documentation, your application for licensure will be reviewed by the Secretary Treasurer to ensure compliance (NAC 631.050). If the application is found to be in compliance the Secretary Treasurer shall instruct the Executive Director to issue the license.

Activation/Renewal of License:

Upon approval of your application for licensure by the Board, you will receive an approval packet to include, but not limited to, the license number assigned, the activation/renewal form to include fee amounts specific for your licensure type (prorated), information regarding, continuing education requirements and business license information.

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2" x 2" color photo of applicant taken within the last 6 months must be affixed to this space.

I hereby make application for Nevada Dental Therapy licensure by: (Please check one below)

Licensure by ADEX Exam (SB 366): $1000 ☐	Licensure by WREB Exam (SB 366): $1000 ☐
Current Dental Hygiene No: _____	Special Health Endorsement Permit Yes ☐ No ☐
Military by Reciprocity/Credential: $500.00 ☐	License by Endorsement: $1000 (Must be licensed as a dental therapist for 5 years) ☐

NOTE: *An application is considered complete when the application, all required documents, background information, and fees are on file with the Board office. APPLICATION FEES MUST BE PAID IN ADVANCE AND MAY NOT BE REFUNDED PURSUANT TO NEVADA REVISED STATUTE (NRS) 631.345.*
Please type or print legibly. All questions must be answered. If additional space is needed, attach a separate sheet identifying additional information by Section number. Applicants acknowledge they have a continuing responsibility to update all information contained in this application until such time as the Board takes final action on this application. Failure of an applicant to update the information prior to final action of the Board is grounds for subsequent disciplinary action.

Last:	*First:*	*Middle:*	*Suffix:*

Soc. Security #:	*Age:*	*Male* ☐ *Female* ☐	*Birthdate:*	*Birthplace (City, County, State, & Country):*

Have you ever been known by any other name?	Yes ☐	No ☐
If yes, state in full every other name by which you have been known, the reason therefore, and the inclusive dates so known:		
If a married woman, state maiden name:		
If a name change was made by court order, attach a CERTIFIED COPY of the court order.		
Are you a U.S. born citizen?	Yes ☐	No ☐
If no, are you naturalized?	Yes ☐	No ☐

If yes, naturalization #	Naturalization Date:	Place:

If no, were you born abroad of US citizens?	Yes ☐	No ☐
If no, are you a legal resident?	Yes ☐	No ☐
Is your application for naturalization pending? Date of Application: Place:	Yes ☐	No ☐

You must submit appropriate proof of Citizenship or legal documentation for lawful entitlement to remain in the U.S. and work in the U.S

(A) HOME ADDRESS & PREVIOUS ADDRESS HISTORY

Current Home Address:	*City:*	*State:*	*Zip code:*

Telephone Residence:	*Telephone Cell:*	*Email address:*

Mailing Address: This is the address that all correspondence from NSBDE will be mailed.
If same as current home address please check box. ☐

Mailing Address (If different):	*City:*	*State:*	*Zip Code:*

Telephone Residence:	*Telephone Cell:*	*Email address:*

(B) PREVIOUS STREET ADDRESS

List all home addresses for the past seven (7) years. If you cannot recall certain information please indicate cannot recall. Do not leave blank. Please be sure that if you were in school you have a home address listed in the same state you went to school.
(Please add additional pages as needed)

1. Address :	*City:*	*State:*	*Zip Code:*
County:	***Dates:***	***to***	
2. Address :	*City:*	*State:*	*Zip Code:*
County:	***Dates:***	***to***	
3. Address :	*City:*	*State:*	*Zip Code:*
County:	***Dates:***	***to***	
4. Address :	*City:*	*State:*	*Zip Code:*
County:	***Dates:***	***to***	
5. Address :	*City:*	*State:*	*Zip Code:*
County:	***Dates:***	***to***	
6. Address :	*City:*	*State:*	*Zip Code:*
County:	***Dates:***	***to***	
7. Address :	*City:*	*State:*	*Zip Code:*
County:	***Dates:***	***to***	
8. Address :	*City:*	*State:*	*Zip Code:*
County:	***Dates:***	***to***	
9. Address :	*City:*	*State:*	*Zip Code:*
County:	***Dates:***	***to***	

(C) 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	☐
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	☐

(D) EDUCATION & CERTIFICATIONS (CODA Accredited Programs)

Dental Hygiene Program:	Dental Therapy Program:
University/ College:	*University/ College:*
City:	*City:*
State:	*State:*
Years Attended: (month/year) to	Years Attended: (month/year) to
Graduation Date:	Graduation Date:
Degree Earned: RDH ☐	Degree Earned: Dental Therapy (DT) ☐

(E) LASER USE AND CERTIFICATION

I utilize laser radiation in the performance of my practice of dental therapy. Yes ☐ No ☐

I certify that each laser I use in my practice of dental therapy has been cleared by the United States Food and Drug Administration for use in dentistry. Yes ☐ No ☐

Attach a copy of proof of course completion of laser proficiency indicating successful completion of a recognized course pursuant to Board regulation NAC 631.033 and NAC 631.035 based on the curriculum guidelines and standards for dental laser education as adopted by the Academy of Laser Dentistry.

(F) CONTINUED CLINICAL COMPETENCY

Have you been out of active practice for two or more years just prior to completing this application? Yes ☐ No ☐

If yes, attach a separate sheet with details of how you have maintained your clinical skills.

(G) HISTORY OF IMPAIRMENT

(1) **Do you now, or have you ever, abused alcohol, other chemical substances, or do you have any medical/mental impairments or emotional condition(s) that would impair your ability to perform as a licensee pursuant to NRS and NAC Chapters 631?** *(If yes, submit details on separate sheet)* Yes ☐ No ☐

(2) **Do you now, or have you ever had, any contagious or infectious disease(s) that would impair your ability to perform as a licensee pursuant to NRS and NAC Chapters 631?** *(If yes, submit details on separate sheet)* Yes ☐ No ☐

(H) DENTAL PRACTICE & EMPLOYMENT HISTORY

Have you ever been engaged in private dental therapy, been employed as a dental therapist, been self-employed or done business under a fictitious name (D.B.A.)? **Yes** ☐ **No** ☐

If yes, list the following information for the past ten years including the dates you practiced dental therapy: the names of all employers; partners, associates or persons sharing office space; list dates of self-employment and nature of business; list all fictitious names (D.B.A.), dates and nature of business; and the reason for leaving each practice. If you were unemployed for any period of time please write the month and year of unemployment. (Use additional sheets if necessary)

Current Practice Address (If any):	*City:*	*State:*	*Zip Code:*

Telephone:	*Fax:*	*Email address:*

(I) PREVIOUS EMPLOYMENT

1. Practice Address:	*City:*	*State:*	*Zip Code:*

From: *To:* *(Include month/year)*	**Telephone:**

Name of Employers, Associates, Etc…	*Reason for leaving:*

2. Practice Address:	*City:*	*State:*	*Zip Code:*

From: *To:* (Include month/year)	**Telephone:**

Name of Employers, Associates, Etc…	*Reason for leaving:*

3. Practice Address:	*City:*	*State:*	*Zip Code:*

From: *To:* (Include month/year)	**Telephone:**

Name of Employers, Associates, Etc…	*Reason for leaving:*

4. Practice Address:	*City:*	*State:*	*Zip Code:*

From: *To:* (Include month/year)	**Telephone:**

Name of Employers, Associates, Etc…	*Reason for leaving:*

5. Practice Address:	*City:*	*State:*	*Zip Code:*

From: *To:* (Include month/year)	**Telephone:**

Name of Employers, Associates, Etc…	*Reason for leaving:*

(J) EXAMINATION AND LICENSURE HISTORY

NATIONAL BOARD EXAMINATION: Joint Commission Examination

Date Taken: **PASS** ☐ **FAIL** ☐

Please list below all Dental Therapy clinical examinations in which you have participated: ***(Use additional sheets if necessary)***

REGIONAL CLINICAL EXAMS:

ADEX ☐ **Date(s) of Clinical Examination:** **to** **PASS** ☐ **FAIL** ☐

WREB ☐ **Date(s) of Clinical Examination:** **to** **PASS** ☐ **FAIL** ☐

STATE/OTHER EXAMS:

State, Territory, DC:

Date(s) of Clinical Examination: **to** **PASS** ☐ **FAIL** ☐

State, Territory, DC:

Date(s) of Clinical Examination: **to** **PASS** ☐ **FAIL** ☐

Have you ever applied for a license to practice dental therapy? **Yes** ☐ **No** ☐

If yes, list the following for each state, territory or the District of Columbia. Use additional sheets if necessary:

State, Territory, DC:	**Date of Application:**
Result of Application (Granted, Denied,Pending):	
State, Territory, DC:	**Date of Application:**
Result of Application (Granted, Denied,Pending):	
State, Territory, DC:	**Date of Application:**
Result of Application (Granted, Denied,Pending):	

1	**Have any proceedings been initiated against you to revoke or suspend your dental hygiene and/or dental therapy license?**	**Yes** ☐	**No** ☐
2	**At the time you filed this application, were any disciplinary proceedings pending against you, including complaints or investigations, in any other state, territory or the District of Columbia?**	**Yes** ☐	**No** ☐
3	**Have you ever been terminated or attempted to terminate or surrender a dental therapy license in any state, territory or the District of Columbia?**	**Yes** ☐	**No** ☐
4	**Have you ever been denied a dental therapy license in this state, another state, or a territory of the U.S. or the District of Columbia?**	**Yes** ☐	**No** ☐

If you answered 'yes' to questions J1, J2 , J3 and/or J4, provide a full explanation of each answer on a separate sheet and attach to this application.

(K) MALPRACTICE

Have you ever had any claims of malpractice filed against you? Yes ☐ No ☐

If yes, list all malpractice, neglience lawsuits and claims you have ever had against you. Include dates, names, settlements or resolutions. Please include malpractice and lawsuits that were dismissed. Provide additonal pages as needed.

Do you or have you ever carried malpractice (professional liability) insurance? Yes ☐ No ☐

List all malpractice carriers since licensed or for the past 10 years (which ever is longer). Leave no time gaps and account for periods with no insurance. Provide additional pages as needed.

Carrier:		*Policy Number:*	
Address :	*City:*	*State:*	*Zip Code:*
From: *To:* (Include month/year)	Telephone:		
Carrier:		*Policy Number:*	
Address :	*City:*	*State:*	*Zip Code:*
From: *To:* (Include month/year)	Telephone:		
Carrier:		*Policy Number:*	
Address :	*City:*	*State:*	*Zip Code:*
From: *To:* (Include month/year)	Telephone:		
Carrier:		*Policy Number:*	
Address :	*City:*	*State:*	*Zip Code:*
From: *To:* (Include month/year)	Telephone:		
Carrier:		*Policy Number:*	
Address :	*City:*	*State:*	*Zip Code:*
From: *To:* (Include month/year)	Telephone:		
Carrier:		*Policy Number:*	
Address :	*City:*	*State:*	*Zip Code:*
From: *To:* (Include month/year)	Telephone:		

(L) MORAL CHARACTER

1	**Have you ever been reprimanded, censored, restricted or otherwise disciplined?**	**Yes** ☐	**No** ☐
2	**Have any claims or complaints of malpractice, formal or informal, ever been made or filed against you, or have any proceedings been instituted against you?**	**Yes** ☐	**No** ☐
3	**Have you ever been arrested, convicted, charged with, entered a plea of nolo contendere or pleaded guilty to the violation of any law [misdemeanor(s) or felony(ies)]?**	**Yes** ☐	**No** ☐

If your answer is 'yes' to any of the foregoing questions (1-3), furnish a written statement of each occurrence giving the complete facts. For each incident, state the date, case number, the nature of the charge the disposition of the matter, and the name and address of the authority in possession of the records thereof. You must provide certified copies of any arrest or conviction and/or any plea agreements entered into for any felony(ies) or misdemeanor(s).

4	**Have you ever been denied participation in, or suspended from the Medicaid or Medicare benefit program?**	**Yes** ☐	**No** ☐

If your answer is 'yes' to questions 4, furnish a written statement of each occurrence giving the complete facts. For each incident, state the date, the nature of the charge the disposition of the matter, and the name and address of the authority in possession of the records thereof.

(M) STATEMENT OF CHILD SUPPORT

Pursuant to state and federal mandated requirements, I further certify that (CHECK the appropriate box):

1	**I am NOT subject to a court order for the support of one or more children.**	☐
2	**I AM subject to a court order for the support of one or more children and: (*continue to 2a or 2b below*)**	☐
2a	**I am NOT in compliance with a plan approved by the district attorney or other public agency enforcing the order for the payment of the amount owed pursuant to the court order for the support of one or more children.**	☐
2b	**I AM in compliance with a plan approved by the district attorney or other public agency enforcing the order for the payment of the amount owed pursuant to the court order for the support of one or more children.**	☐

(N) AFFIDAVIT AND PLEDGE

I hereby expressly waive all provisions of law forbidding any physician or other person who has attended or examined me or who may hereafter attend or examine me from disclosing any knowledge or information that is thereby acquired, and I hereby consent that such knowledge or information may be disclosed to the Nevada State Board of Dental Examiners.

The person named as the applicant in the foregoing application and questionnaire, being first duly sworn, deposes and says: I am the applicant for dental licensure referred to; and I have carefully read and understand the questions in the foregoing questionnaire and have answered them truthfully, fully, and completely, without mental reservation of any kind. I further understand I have a continuing obligation to inform the Board should any of my answers since filing this application change prior to the Board issuing my license. In the event I fail to update the answers which have changed since submitting this application, I understand that such failure is ground for revocation of any license issued or denial of the application.

I hereby authorize educational and other institutions, my references (past and present), business and professional associates (past and present), insurance carriers, professional societies, governmental agencies and instrumentalities (local, state, federal or foreign), and independent information gathering services to release to the Nevada State Board of Dental Examiners any information, files or records requested by the Board in connection with the processing of this application.

I hereby pledge myself to the highest standards and ethics in the Practice of Dentistry and further pledge to abide by the laws and regulations pertaining to the practice of dentistry. I understand that a violation of this pledge may be deemed sufficient cause for the revocation of a license issued by the Board.

I hereby understand and agree that the title of all licenses shall remain with the Nevada State Board of Dental Examiners and subject to surrender by Order of said Board.

I UNDERSTAND THAT ANY OMISSIONS, INACCURACIES, OR MISREPRESENTATIONS OF INFORMATION ON THIS APPLICATION ARE GROUNDS FOR REJECTION OF THIS APPLICATION AND THE REVOCATION OF A LICENSE WHICH MAY HAVE BEEN OBTAINED THROUGH THIS APPLICATION.

APPLICANT

_____

Applicant Signature

_____

Applicant (printed) Last Name, First, MI, Suffix (e.g., Jr.)

Date of Signature (must correspond with notory date)

_____

Applicants Date of Birth (month/day/year)

_____

Social Security Number

NOTORY

State of _____ **County of** _____

The statement on this document are subscribed and sworn before me this

_____ **day of** _____ **,20** _____

_____

Notory Public

_____

My Commission Expires

Nevada State Board of Dental Examiners

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NOTARIZED AUTHORIZATION FOR RELEASE OF INFORMATION, DOCUMENTS AND RECORDS

I, _____, designate the Nevada State Baord of Dental Examiners to collect, verify and maintain information, and copies of documents and records that can subsequently be provided to professional licensing boards, hospitals and other entities when I apply for licensure, staff membership, employment, or other privileges.

I request and authorize every person, institution, professional licensing board or any state in which I hold or may have held a license to practice my professional, Joint Commission on National Dental Examinations, hospital, clinic, government agency (local, state, federal or foreign), law enforcement agency, or other third parties and organizations, and their representatives to release information, records, transcripts, and other other documents, concerning my professional qualifications and competence, ethics, character, and other information pertaining to me to the Nevada State Board of Dental Examiners.

I further request and authorize that the requested information, documents and records be sent directly to:

Nevada State Board of Dental Examiners
6010 S Rainbow Blvd., Suite A-1
Las Vegas, NV 89118

I hereby release, discharge, and hold harmless the Nevada State Board of Dental Examiners, or representatives and any person furnshing information, records, or documents of any and all liablilty. I authorize the Nevada State Board of Dental Examiners to release information, material, documents, orders or the like relating to me or this application to any entity at my request.

By my signature below, I acknowledge that information, documents and records required to be furnished by another organization, educational institutions, individual, or any person or groups must be sent directly by such persons to Nevad State Board of Dental Examiners. I understand that Nevada State Board of Dental Examiners will not accept such information, records, or documents forwarded by me.

A photocopy or facsimile of this authorization shall be as valid as the orginal and shall be valid for a period of one (1) year from the date of signature.

APPLICANT

_____
Applicant Signature

_____
Applicant (printed) Last Name, First, MI, Suffix (e.g., Jr.)

_____
Date of Signature (must correspond with notory date)

_____
Applicants Date of Birth (month/day/year)

_____
Social Security Number

NOTORY

State of _____ **County of** _____

The statement on this document are subscribed and sworn before me this

_____ **day of** _____ **,20** _____

_____
Notory Public

_____
My Commission Expires