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

LIMITED LICENSE PERMIT APPLICATION

Name:	*License Number:*

Nevada System of Higher Education

University of Nevada Las Vegas	☐	**College of Southern Nevada**	☐
Roseman University of Health Sciences	☐	**Truckee Meadows Community College**	☐

Educational Facility Address:	*City:*	*State:*	*Zip:*

Telephone:	*Fax:*	*Email:*

PRIVATE PRACTICE

**** CANNOT EXCCEED 16 HOURS PER WEEK****

Practice Name:			
Practice Address:	*City:*	*State:*	*Zip:*

Telephone:	*Fax:*	*Email:*

ENDORESMENT CERTIFICATION OF DEAN/PROGRAM DIRECTOR FOR LIMITED LICENSE PRIVATE PRACTICE

I HERBY CERTIFY that approval has been granted for _____ (name of applicant) to enter into private practice pursuant to NRS 631.271 (3)(4) at the location identified above, for hours not to exceed 16 hours per week.

OFFICIAL SEAL OF ACCREDITED DENTAL SCHOOL OR UNIVERSITY

_____

ORIGINAL SIGNATURE OF DEAN / PROGRAM DIRECTOR (No stamped signatures)

_____

Printed name of Dean / Program Director and date

The following information and documentation must be received by the Board office prior to consideration of permit:

1. **Complete and sign application form;**
2. **Endorsement signed from dean/program director;**
3. **Submit Certified Verification of Licensure Letter from ALL States you are licensed (other than Nevada) (Please have these letters mailed directly to the Board Office;**
4. **Submit Current National Practitioners Data Bank (NPDB) Self Query Report.**

****ADDITIONAL LOCATIONS REQUIRE SERPARATE PERMIT APPLICATON****

AFFIDAVIT AND PLEDGE

I hereby authorize educational and other institutions, 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/Dental Hygiene and further pledge to abide by the laws and regulations pertaining to the practice of dentistry/dental hygiene. 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

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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

Revised 1/2014