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 RESTRICTED GEOGRAPHICAL LICENSE
(DENTAL OR DENTAL HYGIENE)

Thank you for your interest in applying for a restricted geographical license in the State of Nevada. Pursuant to state law, **ALL** applicants for a restricted geographical dental or dental hygiene license must meet the following eligibility requirements as set forth in NRS 631.230 and NRS 631.290:

(a) Is over the age of 21 years **(dental);** Is over the age of 18 years **(dental hygiene)**
(b) Is a citizen of the United States, or is lawfully entitled to remain and work in the United States;
(c) Is a graduate of an accredited dental school or college; or an accredited dental hygiene program for dental hygiene
(d) Is of good moral character

If you meet **all** of the requirements listed in item (a) through (d) above, you may be eligible to apply for licensure.

For those applying for a restricted geographical license, the Board may without a clinical examination issue a restricted geographical license to practice dentistry or dental hygiene to a person:

a) A board of county commissioners submits a request that the Board of Dental Examiners of Nevada waive the requirements of NRS 631.240 or 631.300 for any applicant intending to practice dentistry or dental hygiene in a rural area of a county in which dental or dental hygiene needs are underserved as that term is defined by the officer of rural health of the University of Nevada School of Medicine;

(b) Two or more boards of county commissioners submit a joint request that the Board of Dental Examiners of Nevada waive the requirements of NRS 631.240 or 631.300 for any applicant intending to practice dentistry or dental hygiene in one or more rural areas within those counties in which dental or dental hygiene needs are underserved as that term is defined by the officer of rural health of the University of Nevada School of Medicine; or

(c) The director of a federally qualified health center or a nonprofit clinic submits a request that the Board waive the requirements of NRS 631.240 or 631.300 for any applicant who has entered into a contract with a federally qualified health center or nonprofit clinic which treats underserved populations in Washoe County or Clark County.

2. A person may apply for a restricted geographical license if the person:

(a) Has a license to practice dentistry or dental hygiene issued pursuant to the laws of another state or territory of the United States, or the District of Columbia;

(b) Is otherwise qualified for a license to practice dentistry or dental hygiene in this State;
(c) Pays the application, examination and renewal fees in the same manner as a person licensed pursuant to NRS 631.240 or 631.300;
(d) Submits all information required to complete an application for a license; and
(e) Satisfies the requirements of NRS 631.230 or 631.290, as appropriate.

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.

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 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:

Dental:

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, business license, continuing education requirements, duties delegable to dental assistants, State Board of Pharmacy regarding permits for controlled substances and the Prescription Monitoring Program access information

Dental Hygiene:

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, business license, continuing education requirements, duties delegable to dental assistants

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APPLICANT'S CHECKLIST FOR RESTRICTED GEOGRAPHICAL LICENSURE–

Dental and Dental Hygiene

(List of items to be completed by you)

_____ Complete Application

_____ Submit Application Fee

_____ Submit 2 x 2 color photo attached to the application

_____ Submit National Practitioners Data Bank (NPDB) Self Query Report

_____ Submit Fingerprints Cards **(Return to Board office)**

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.

_____ Complete On–line Jurisprudence Examination

_____ Submit copy of current CPR Card

_____ Submit Certified copy of Citizenship Documents

_____ Submit Certified Copy of Transcript from Dental/Dental Hygiene Program

(See enclosed hand–out for instructions)

_____ Submit Certified Certificates of **ALL** Clinical Examinations you participated in as a candidate
(Please have these certified certificates mailed directly to the Board office)

_____ Submit Certified Verification of Licensure Letters from **ALL** states you are licensed
(Please have these letters mailed directly to the Board office)

_____ Submit written request from Board of County Commissioners or FQHC
to waive clinical examination **(Send request directly to Board office)**

NOTE: When the Board office has received the completed application, applicable application fee and all required documents as set forth in NAC 631.030, your application will be reviewed by the Secretary-Treasurer for the Board. Upon review by the Secretary–Treasurer and having met all requirements, the Secretary Treasurer shall instruct the Executive Director to issue the license.

NOTE: If hand delivering any on the items identified above, the materials **MUST** be in sealed envelopes

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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 licensure by: *(Please check one below)*

Licensure by ADEX Exam (NRS 631.240): $1200 ☐	**Licensure by WREB Exam (NRS 631.240): $1200** ☐

Licensure by Credential (NRS 631.255): $1200
(Please select specialty below)

Indicate Specialty: **Board Eligible** ☐ **Diplomate** ☐

Orthodontia	☐	**Prosthodontia**	☐	**O & M Pathology**	☐
Endodontia	☐	**Pediatric Dentistry**	☐	**O & M Radiology**	☐
Periodontia	☐	**Public Health Dentist**	☐	**O & M Surgery**	☐

Limited Licensure (NRS 631.271): $125		**Restricted Geographical (NRS 631.274): $600**	
Resident: ☐	**Instructor:** ☐	**Underserved County(ies):** ☐	**FQHC or Non-Profit:** ☐
Indicate Residency Program:	***Indicate Instructor Facility:***	***Indicate County(ies)***	***Indicate FQHC Facility or Non Profit***

Active Military, Retired Military or Spouse of Military by Reciprocity: $600.00 ☐

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. YOU WILL BE NOTIFIED WITHIN 15 BUSINESS DAYS UPON APPROVAL OF YOUR APPLICATION BY THE BOARD.*

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? **Yes** ☐ **No** ☐

Date of Application: **Place:**

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:*

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***	
10. 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

Doctoral:	Post Doctoral:
University/ College:	*University/ College:*
City:	*City:*
State:	*State:*
Years Attended: (month/year) to	Years Attended: (month/year) to
Graduation Date:	Graduation Date:
Degree Earned: DDS ☐ DMD ☐	Specialty (MS):

(E) LASER USE AND CERTIFICATION

I utilize laser radiation in the performance of my practice of dentistry.	Yes ☐	No ☐
I certify that each laser I use in my practice of dentistry 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 one 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 practice, been employed as a dentist, 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 dentistry: 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

Part I	**Date Taken:**	**PASS** ☐	**FAIL** ☐
Part II	**Date Taken:**	**PASS** ☐	**FAIL** ☐

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

CLINICAL EXAMS:

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

OTHER EXAMS:

Regional/State, Territory, DC:			
Date(s) of Clinical Examination:	**to**	**PASS** ☐	**FAIL** ☐
Regional/State, Territory, DC:			
Date(s) of Clinical Examination:	**to**	**PASS** ☐	**FAIL** ☐

Have you ever applied for a license to practice dentistry? **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 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 license in any state, territory or the District of Columbia?**	**Yes** ☐	**No** ☐
4	**Have you ever been denied a dental 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

As a member of any profession or association connected with the practice of dentistry, or as a staff member at a hospital, outpatient clinic, or surgery center, or as a holder of public office:

1	Have you ever been suspended or otherwise disqualified?	Yes ☐	No ☐
2	Have you ever been reprimanded, censored, restricted or otherwise disciplined?	Yes ☐	No ☐
3	Have any charges or complaints, formal or informal, ever been made or filed against you, or have any proceedings been instituted against you? (Dental Society, Associations, Hospitals, or States)	Yes ☐	No ☐
4	Have your clinical privileges or procedures been restricted by any hospital, outpatient clinic or surgery center?	Yes ☐	No ☐
5 (a)	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 ☐
(b)	Have you ever received a citation or been cited for any traffic violations?	Yes ☐	No ☐

If your answer is 'yes' to any of the foregoing questions (1-5), 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).

6	Have you ever been declared a ward of any court, or adjudged as incompetent, or have any proceedings ever been brought to have you declared a ward of any court or adjudged as incompetent, or have you ever been committed to any institution?	Yes ☐	No ☐
7	Have you ever been dropped, suspended, expelled or disciplined by any school or college for any cause whatsoever:	Yes ☐	No ☐

If your answer is 'yes' to questions 6 or 7, 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.

8	Have you ever been denied participation in, or suspended from the Medicaid or Medicare benefit program?	Yes ☐	No ☐
9	Have you ever had a civil court action in which you were either the plaintiff or defendant? (please include all civil actions civil disputes, negligence or personal injury)	Yes ☐	No ☐

If your answer is 'yes' to questions 8 or 9, 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.

10	Do you hold a DEA license?	Yes ☐	No ☐ If yes list DEA Number #
11	Have you ever surrendered your DEA number or had it revoked or restricted?	Yes ☐	No ☐

(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

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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

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REQUEST FOR OFFICIAL TRANSCRIPTS DENTAL

Pursuant to NAC 631.230 and NAC 631.030, applicants for dental licensure in the State of Nevada must present official certified copies of your transcripts indicating you have been awarded a degree in dental surgery/medicine from an ADA accredited dental school or college.

Please be advised, you will be required to request a certified copy of your dental school transcript be sent to the Board office at the address listed above. If you hand deliver a certified copy of your transcript, the documents must be in a sealed envelope.

Please be advised, your application will not be deemed complete until our office has received the official transcript from your dental school.

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National Practitioner Data Bank Self-Query Report

All applicants for dental or dental hygiene licensure are required to self-query the National Practitioner Data Bank. The self-query must be completed on the internet. You will need a credit card for payment of the querying fees. Instructions for accessing the self-query forms are as follows:

Go to: https://www.npdb.hrsa.gov/ext/selfquery/SQHome.jsp

- Click on 'Place a Self-Query Order'; read the agreements, accept the terms and click 'Submit and Continue'
- Complete steps 1-4 on-line following the instructions

Federal law requires that the self-query results be provided directly to you, the applicant/practitioner, and not a third party. You will be provided with an electronic copy (accessible online) and a paper copy (by mail) of your report. You may submit the original report you receive by mail to the Board office to the address at the top of this page, or submit the completed report by email by following these instructions:

- Open the email you received from the NPDB and click on the link provided in that email
- Sign-in to open/view your report
- From the open report, save a copy of the report PDF to your computer
- Close the report and sign-out of the NPDB
- Return to the open email from the NPDB and click 'Forward'
- Enter the Board email address of nsbde@nsbde.nv.gov in the 'To' field, attach a copy of the PDF report to the email and click 'Send'. The original email from the NPDB is required to view the email thread and confirm authenticity.

It is important you follow these instructions for the Board staff to verify the authenticity of the report.
PLEASE NOTE: You must use a non-Apple product (i.e. – anything but an iPhone, iPad, Mac, etc.) to forward the information by email. The Board staff is unable to view all required information if submitted using an Apple product. We apologize for the inconvenience.

If you have questions pertaining to your self-query, you may contact: **Data Bank Customer Service at 800-767-6732.**

Nevada 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

Name of person Requesting:	**Mailing Address (where to mail document requested):** _____ _____
Contact Telephone Number: ( ) --	**Suite No. :** _____ **City:**_____
NV License Number: ☐ **Dental** ☐ **Dental Hygiene**	**State:** _____ **Zip Code:** _____

DESCRIPTION OF PURCHASE — TOTAL $

Dental Application Fees:

- ☐ WREB Dental ($1200)
- ☐ ADEX Dental ($1200)
- ☐ Specialty Credential ($1200)
- ☐ Geographically Restricted ($600)
- ☐ Limited License ($125)
- ☐ Limited License for Supervision ($100)
- ☐ Restricted ($125)
- ☐ Specialty (NV licensed Dentist Only) ($125)
  (*If applying for a general dental license and specialty license concurrently, application fee will be $1325*)

Dental Hygiene Application Fees:

- ☐ WREB Hygiene ($600)
- ☐ ADEX Hygiene ($600)
- ☐ Geographically Restricted ($150)
- ☐ Limited License ($125)
- ☐ Local Anesthesia/N2O Permit(s) ($25 each)

Anesthesia Permit Fee:

- ☐ General Anesthesia Application ($750)
- ☐ Conscious Sedation Application ($750)
- ☐ Administration Re-inspection Fee ($500)
- ☐ Site Permit Application ($500)
- ☐ Site Re-inspection Fee ($350)

Other: _____
_____
_____
_____

Licensure Fees:

Dental Renewal:
- ☐ Active ($600)
- ☐ Inactive ($200)
- ☐ Limited ($200)
- ☐ Restricted ($100)
- ☐ Retired ($50)

Hygiene Renewal:
- ☐ Active ($300)
- ☐ Inactive ($50)
- ☐ Limited ($200)
- ☐ Retired ($50)

Reinstatement Fee:
- ☐ Revoked ($500)
- ☐ Suspended ($300)

- ☐ General Anesthesia Permit Renewal ($200)
- ☐ Conscious Sedation Permit Renewal ($200)
- ☐ Site Permit Renewal ($200)
- ☐ License Reactiviation ($300)

Certificate(s):

- ☐ Wall Certificate ($25)
- ☐ Pocket Card ($25)
- ☐ Dental Anesthesia Wall Certificate ($25)
- ☐ Local anesthesia/N2O Wall Certificate ($25)
- ☐ Exam Verification Certificate ($25)
- ☐ License Verification Certificate ($25)

Miscellaneous:

- ☐ Continuing Education Provider Fee
  ($150 1st hour, $50 each additional hours)
- ☐ NRS/NAC Booklets ($3 each)
- ☐ Return Check Fee ($25)
- ☐ Change of Address Fine ($50)
- ☐ Investigation Costs
- ☐ Civil Penalty

Name on Credit Card:	**Method of Payment:** **Master card** ☐ **Visa** ☐ **Discover Card** ☐ **Check** ☐
Credit Card Billing Address: _____ _____ **Suite No. :** _____ **City:**_____ **State:** _____ **Zip Code:** _____	**Credit Card Number:** __ __ __ __ - __ __ __ __ - __ __ __ __ - __ __ __ __
	Exp. Date: _____ - _____ **Security Code#** __ __ __

Purchasers Signature: _____ **Date:** _____

****PERSONAL & BUSINESS CHECKS ONLY ACCEPTED IF YOU ARE A CURRENT LICENSEE IN GOOD STANDING****
****THERE IS A 7 TO 15 BUSINESS DAY PROCESSING PERIOD FOR ALL REQUESTS****