



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

CREDIT CARD AUTHORIZATION FORM

Name of Person Requesting: _____		Mailing Address (where to mail document requested): _____	
Telephone Number: () - -		Suite No.: _____ City: _____	
NV License Number:	<input type="checkbox"/> Dental <input type="checkbox"/> Dental Hygiene	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 (\$600)
<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 (\$300)

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)

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

Renewal: \$ _____ Permit No.: _____ (choose one): <input type="checkbox"/> General Anesthesia <input type="checkbox"/> Moderate Sedation <input type="checkbox"/> Site Permit
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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.: _____

Permit Re-Inspection: \$ _____ (choose one): <input type="checkbox"/> Administration Permit Re-inspection (\$500) <input type="checkbox"/> Site Permit Re-inspection (\$350)

Other: _____ _____ _____

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: \$ _____	

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