BIENNIAL DENTAL HYGIENE LICENSE RENEWAL

Office Use Only

Date Received: _____

Payment Amount: _____

Staff Initials: _____

License Status: _____

Name: _____ **License Number:** _____

Mailing Address: _____

_____

☐ Change of Mailing Address

Mailing Address Is Public Information

NEVADA STATE BOARD OF DENTAL EXAMINERS
6010 S. Rainbow Blvd. A-1
Las Vegas, NV 89118
(702) 486-7044

LICENSE STATUS: _____

READ THIS FORM CAREFULLY

RENEWAL OF YOUR NEVADA HYGIENE LICENSE IS COMPLETE UPON THE BOARD'S PHYSICAL RECEIPT OF ALL REQUIRED INFORMATION NO LATER THAN JUNE 30, 2014: INCOMPLETE RENEWAL APPLICATIONS WILL BE RETURNED.

FOR ACTIVE LICENSE RENEWALS:	This form **with all questions answered** and affidavit signed; Renewal fee in the appropriate amount; Current CPR certification dates and total number of Continuing Education hours entered on form;	_____$300
FOR INACTIVE, RETIRED OR DISABLED LICENSE RENEWALS:	This form **with all questions answered** and affidavit signed. (No Continuing Education list or CPR required for inactive, retired or disabled renewal **ONLY IF LICENSE STATUS IS CURRENTLY INACTIVE, RETIRED or DISABLED**)	_____$50

DENTAL HYGIENE LICENSE RENEWAL – JULY 1, 2014 – JUNE 30, 2016

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 "terrorism" course is in addition to your required CE hours. You must provide a copy of the certificate of attendance to receive credit for this "terrorism" course.

Instructional CEU for Terrorism Course On File: _____

I 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. **Place Check** ☐

Current CPR dates on file: Begin: _____ **End:** _____ **Enter new dates: Begin** _____ **End:** _____

I attest that I have inserted valid dates of current 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 3 years and may be audited by the Board pursuant to NAC 631.177. **Place Check** ☐

FOR PHDHE HYGIENISTS ONLY

PHDHE Exp Date:	**Check Box to Renew:** ☐ **Yes** ☐ **No**

For reporting purposes, please provide the total number of each procedure provided/completed through your Public Health Endorsement (If you did not provide a particular service/procedure, enter the number zero -0- on the corresponding line):

Screenings/Assessments _____ **Child Prophy** _____ **Sealants** _____ **X-rays** _____ **Adult Prophy** _____ **Adult Root Planing** _____

Other _____

I attest that I hold current malpractice insurance coverage for services performed through all public health programs. **Place Check** ☐

Pursuant to NAC 631.260, I certify that all persons I supervise (listed below), except for licensed dental hygienists, to assist in radiographic and infection control procedures, are qualified to assist in such procedures.

EMPLOYEE	TITLE	DATE BEGAN ASSISTING

IF YOU HAVE MORE ASSISTANTS, PLEASE LIST ANY OTHERS ON A SEPARATE SHEET

ADDRESS VERIFICATION

Verify practice and home addresses shown below and the mailing address at the top left of the first page. All addresses are treated individually. If any changes are necessary, please check the box next to EACH ADDRESS that requires change and provide the current information on a separate sheet. 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.

IF YOU HAVE MORE THAN ONE OFFICE, PLEASE LIST ANY OTHERS ON A SEPARATE SHEET INCLUDING LICENSED DENTIST NAME

NAME/PRACTICE NAME/DBA: _____ **OFFICE TELEPHONE:** _____

OFFICE ADDRESS: _____ **OFFICE FAX:** _____

CITY/STATE/ZIP: _____ **TOTAL NUMBER OF CURRENT OFFICE LOCATIONS:** ___

EMAIL: _____

☐ **Change of address (Note on separate sheet)**

HOME ADDRESS: _____ **HOME TELEPHONE:** _____

CITY/STATE/ZIP: _____ **HOME FAX:** _____

EMAIL: _____

☐ **Change of address (Note on separate sheet)**

AFFIDAVIT

I hereby certify the following to the Nevada State Board of Dental Examiners for the period of July 1, 2012 through June 30, 2014: (Place X on Yes or No)

1.	Have you been convicted of a felony(ies) and/or misdemeanor(s)? If Yes, you must provide a written statement outlining the facts.	____ **Yes**	____ **No**
2.	Have you had a license to practice dental hygiene suspended, revoked, or placed on probation in another state or territory of the US or the District of Columbia? If Yes, you must provide a written statement outlining the facts.	____ **Yes**	____ **No**
3.	Have you had filings or service or claim(s) or complaint(s) of malpractice or disciplinary action(s) including mandatory supervision, reprimand, or current notice of investigation, in any jurisdiction outside of the State of Nevada pursuant to NAC 631.050 and NAC 631.155? If Yes, you must provide a written statement outlining the facts.	____ **Yes**	____ **No**
4.	Are you subject to a court order for the support of one or more children (i.e. - do you have a child support order?)? (If YES, MUST answer question [a] below)	____ **Yes**	____ **No**
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 of the amount owed pursuant to the court order for the support of one or more children. If you are not in compliance, you must provide a written explanation.	____ **Yes**	____ **No**
5.	Have you conducted practice within the provisions of NRS 631 and NAC 631?	____ **Yes**	____ **No**
6.	Do you have a history of addiction(s) which would impair your practice of dental hygiene pursuant to NRS 631 and NAC 631?.	____ **Yes**	____ **No**
7.	Do you utilize laser radiation in the performance of your practice of dental hygiene? (If YES, MUST answer question [a] below)	____ **Yes**	____ **No**
a.	Have you submitted appropriate certification to the Board pursuant to NAC 631.033 and NAC 631.035?	____ **Yes**	____ **No**
	***If not previously submitted, attach a copy of certification of laser proficiency indicating completion of a course of at least 6 hours in length and based on the curriculum guidelines and standards for dental laser education as adopted by the Academy of Laser Dentistry.*		
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 _____		

REPORT OF EXISTENCE OF NEVADA BUSINESS LICENSE - NRS 622.240

All licensees **MUST** complete this section, regardless of license status. Please select **ONE** option:

☐ I have a Nevada business license number assigned by the Secretary- of State upon compliance with the provisions of NRS Chapter 76.
My Nevada business license number is: _____.

☐ 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.

☐ I do NOT have a Nevada business license number.

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/.

I authorize and empower the Nevada State Board of Dental Examiners or its agent to contact any person, firm, service, agency, or the like to obtain information deemed necessary or desirable by the Board to verify any information contained in my license renewal and affidavit. I understand that any omissions, inaccuracies, or misrepresentations of information on this renewal application are grounds for rejection of this application and the revocation of a license which may have been obtained through this application.

SIGNATURE OF DENTAL HYGIENIST _____ **DATE** _____