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

OFFICE USE ONLY	
Date Received:	
Payment Amount:	
Staff Initials:	

ACTIVE DENTAL HYGIENE LICENSE RENEWAL – JULY 1, 2022 – JUNE 30, 2024

READ THIS FORM CAREFULLY

RENEWAL OF YOUR NEVADA DENTAL LICENSE IS COMPLETE UPON THE BOARD'S PHYSICAL RECEIPT OF ALL REQUIRED INFORMATION NO LATER THAN JUNE 30, 2022: INCOMPLETE RENEWAL APPLICATIONS WILL BE RETURNED.

FOR ACTIVE DENTAL HYGIENE RENEWAL: Complete this form with all questions answered and verification signed, renewal fee in the appropriate amount, and attest to current CPR certification dates and required number of continuing education hours.	**$300**

Last:	*First:*	*Middle:*	*License Number:*

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. All addresses are treated individually.

(Address selected as "Mailing Address" is considered public Information)

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

Name/Practice Name/DBA:		*Office Address:*		
City:	*State:*	*Zip Code:*	*Office Telephone:*	*Office Fax:*
☐ Select if the Practice Address is your mailing address				
Home Address:		*Email:*		
City:	*State:*	*Zip Code:*	*Home Telephone/Cell:*	*Home Fax:*
☐ Select if the Home Address is your mailing address				

REPORT OF EXISTENCE OF NEVADA BUSINESS LICENSE – NRS 622.240

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

IF YOU HAVE MORE THAN ONE, PLEASE LIST ANY ADDITIONAL BUSINESS LICENSES ON A SEPARATE SHEET INCLUDING BUSINESS LICENSE NUMBER, STREET ADDRESS, CITY, STATE AND ZIPCODE.

☐ I do **NOT** have a Nevada business license number.

☐ 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 have a Nevada business license number assigned by the Nevada Secretary of State upon compliance with the provisions of NRS Chapter 76.

Name of Business:

Business license number:	*Street Address:*	*City:*	*State:*	*Zip Code:*

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/.

REPORT OF 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	☐

IF YOU HAVE SERVED MORE THAN ONE MILITARY BRANCH OF SERVICE, PLEASE LIST ANY MILITARY SERVICE ON A SEPARATE SHEET INCLUDING DATE OF SERVICE, MILITARY OCCUPATION SPECIALTY/SPECIALTIES AND BRANCH OF SERVICE.

ADDITIONAL - REPORT OF MILITARY SERVICE (All questions must be answered)

Have you ever served on active duty in the Armed Forces of the United States and separated from such service under conditions other than dishonorable?	**Yes**	**No**
Have you ever been assigned to duty for a minimum of 6 continuous years in the National Guard or a reserve component of the Armed Forces of the United States and separated from such service under conditions other than dishonorable?	**Yes**	**No**
Have you ever served the Commissioned Corps of the United States Public Health Service or the Commissioned Corps of the National Oceanic and Atmospheric Administration of the United States in the capacity of a commissioned officer while on active duty in defense of the United States and separated from such service under conditions other than dishonorable?	**Yes**	**No**

NRS 631.342 BIO TERRORISM

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 course is in addition to your required CE hours. If certificate is not on file with the Board, you must provide a copy of the certificate of attendance to receive credit for this "terrorism" course.

CONTINUING EDUCATION

Refer to NAC 631.175 for CE requirements for the licensure period of July 1, 2020-June 30, 2022. Please list all continuing education certificates of completion issued by recognized providers. All certificates must be maintained for a minimum of three years and may be audited by the Board pursuant to NAC 631.177.

TITLE OF COURSE	UNITS	DATE OF COURSE

IF YOU HAVE MORE CEU's, PLEASE LIST ANY OTHERS ON A SEPARATE SHEET

CPR CERTIFICATION

New CPR dates: **Begin:** _____ **End:** _____

☐ **By selecting this box, I hereby affirm and attest that I have inserted valid dates of 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 three years and may be audited by the Board pursuant to NAC 631.177.**

FOR PHDHE HYGIENISTS ONLY

PHDHE Expiration 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): (Required Field)

Screening/Assessments: _____ **Child Prophy:** _____ **Sealants:** _____ **X-rays:** _____ **Adult Prophy:** _____

Adult Root Planing: _____ **Fluoride Treatment:** **Other (OHI, OHP, Oral Retention checks):** _____

☐ **By selecting this box, I attest that I hold current malpractice insurance coverage for services performed through all public health programs.**

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

VERIFICATION

I hereby certify the following to the Nevada State Board of Dental Examiners for the period of July 1, 2020 – June 30, 2022:

1.	Have you had any claims or complaints of malpractice filed against you, felony or misdemeanor convictions or the suspension, revocation or probation of a license issued by this agency or another licensing jurisdiction during the period of July 1, 2020 to June 30, 2022. (If yes, please provide a written statement outlining the facts.)	**Yes** ☐	**No** ☐
2.	Are you subject to court order for the support of one or more children (i.e. do you have a child support order?)? ***(If yes, you 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 or 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 WRITTEN NOTIFICATION)***	**Yes** ☐	**No** ☐
3.	Have you conducted practice to be in compliance with the provisions of NRS 631 and NAC 631 (Nevada Governing Laws)?	**Yes** ☐	**No** ☐
4.	Do you have a history of addiction(s) which would impair your practice of dentistry/dental hygiene pursuant to NRS 631 and NAC 631?	**Yes** ☐	**No** ☐
5.	Do you utilize laser radiation in the performance of your practice of dentistry/dental hygiene? ***(If yes, you 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** ☐
6.	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** ☐	**No** ☐

By signing below, I hereby affirm and attest, that I have answered the above questions truthfully, accurately, and by me personally, the licensee so named on this form and so stating, under penalties of perjury, that all answers provided herein are provided willfully. I further state that I authorize and empower the Nevada State Board of Dental Examiners or its agents, staff, or appointed authority to contact any person, firm, service, agency, entity, or the like to obtain information deemed necessary or desirable by the Board to verify any information contained in my license renewal application and verification.

Licensee Signature: _____ ***Date:*** _____

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

RENEWAL PAYMENT FORM

CREDIT CARD AUTHORIZATION

RENEWAL FEES MAY BE PAID BY VISA, MASTERCARD, DISCOVER CARD, CHECK, OR MONEY ORDER.

FOR PAYMENT BY CREDIT CARD, PLEASE COMPLETE THE FOLLOWING:

CHARGE RENEWAL FEE OF $: _____ ***TO***

PLEASE CIRCLE ONE: **VISA** **MASTERCARD** **DISCOVER CARD**

CREDIT CARD NUMBER: _____ ***EXP DATE:*** _____

NAME ON CARD: _____ ***SECURITY CODE:*** _____

BILLING ADDRESS FOR CREDIT CARD: _____

_____

_____

SIGNATURE: _____

FOR PAYMENT BY CHECK / MONEY ORDER, MAKE PAYABLE TO: **NEVADA STATE BOARD OF DENTAL EXAMINERS**

INCLUDE ALL FEES