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:	

FOR ACTIVE DENTAL HYGIENE RENEWAL: Complete this form with all questions answered and affidavit 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 631.1p0, all licensees are required to }eep 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.

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				

R POR OF IS NC OF N ADA B SIN SS IC NS NRS 622.240

All licensees M S 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 NO 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 militaryK *(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.

Rev. 03/2024

CONTINUING EDUCATION

☐ ***By selecting this box, I hereby affirm and attest that I have inserted valid dates of CPR certification on this form for a course ta]en 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 631.1mm.***

CPR C R IFICA ION

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

☐ ***By selecting this box, I hereby affirm and 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 631.1mm. In addition to the required CE hours, pursuant to NRS 631.3n2. I affirm that I have fulfilled a mandated four (n) hour*** continuing education course in "terrorism" to be completed two (2) years after receiving licensure in this state.

FOR PHDHE HYGIENISTS ONLY

Chec] 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):

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

Adult Root Planning: _____ ***Fluoride Treatment:*** _____ ***Other (OHI, OHP, Oral Retention chec]s):*** _____

☐ ***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*

ƒIF YOU HAVE MORE ASSISTANTS, PLEASE LIST ANY OTHERS ON A SEPARATE SHEETƒ

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, 2022 to June 30, 2024. (If yes, please provide a written statement outlining the facts.)	☐	☐
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):***	☐	☐
	(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)***	☐	☐
3.	Have you conducted practice within the provisions of NRS 631 and NAC 631?	☐	☐
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?	☐	☐
5.	Do you utilize laser radiation in the performance of your practice of dentistry/dental hygiene? ***(If yes, you MUST answer question (a) below):***	☐	☐
	(a) Have you submitted appropriate certification to the Board pursuant to NAC 631.033 and NAC 631.035?	☐	☐
6.	Do you utilize local anesthesia and/or Nitrous Oxide in the performance of your practice of dental hygiene? ***(If yes, you MUST answer question (a) below):***.	es ☐	No ☐
	(a) I am properly permitted to administer local anesthesia and/or Nitrous Oxide and am currently in compliance with NAC 631.210.	es ☐	No ☐
7.	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.	es ☐	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 affidavit.

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