



NEVADA STATE BOARD OF DENTAL EXAMINERS

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Henderson, Nevada 89014

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OFFICE USE ONLY

Date Received: _____

Payment Amount: _____

Staff Initials: _____

BIENNIAL ACTIVE LICENSE RENEWAL July 1, 2026 – June 30, 2028

RENEWAL OF YOUR NEVADA DENTAL RELATED LICENSE IS COMPLETE UPON THE BOARD'S PHYSICAL RECEIPT OF ALL REQUIRED INFORMATION NO LATER THAN THE DATE REQUIRED PER NRS 631.330. INCOMPLETE OR ILLEGIBLE RENEWAL APPLICATIONS WILL NOT BE PROCESSED.

A. LICENSE TYPE

Dentistry Licenses:	<input type="checkbox"/> General Dentist	<input type="checkbox"/> Specialty Dentist	<input type="checkbox"/> Restricted Geographical
Dental Hygiene Licenses:	<input type="checkbox"/> Registered Dental Hygienist	<input type="checkbox"/> Restricted Geographical	
Dental Therapist:	<input type="checkbox"/> Dental Therapist	<input type="checkbox"/> Restricted Geographical	
Expanded Function Dental Assistant (EFDA):	<input type="checkbox"/> EFDA	<input type="checkbox"/> Restricted Geographical	

ACTIVE LICENSURE DATES FOR RENEWAL PERIOD

Active Licensure Dates:	Start: MM/ DD/ YYYY	End: MM/ DD/ YYYY
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B. CONTACT INFORMATION

First Name:	Middle Name:	Last Name:	License Number:
Home Phone:	Cell Phone:	Email Address:	
<p>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 within thirty (30) days of such change.</p> <p>IF YOU WORK AT OR OWN MORE THAN ONE (1) OFFICE, PROVIDE ALL OTHERS ON A SEPARATE SHEET</p>			
Office Name/Practice Name/DBA:		Office Address:	
City:	State:	Zip Code:	Office Phone: Office Fax:
Address Change Effective Date (if changed):		<input type="checkbox"/> Mailing Address is the same as Office Address	
Home Address:			Apt/Ste:
City:	State:	Zip Code:	
Address Change Effective Date (if changed):		<input type="checkbox"/> Mailing Address is the same as Home Address	
Mailing Address (if applicable):			Apt/Ste:
City:	State:	Zip Code:	
Address Change Effective Date (if changed):			

C. NEVADA BUSINESS LICENSE REPORTING AND AUXILIARIES

All licensees **MUST** complete this section, regardless of license status. Please select **ONE (1)** option:

PER NRS 622.240 - IF YOU HAVE MORE THAN ONE (1), LIST ADDITIONAL BUSINESS LICENSES ON A SEPARATE SHEET INCLUDING BUSINESS LICENSE NUMBER, STREET ADDRESS, CITY, STATE, AND ZIP CODE.

- I do NOT have a Nevada business license number (if selected, skip to Section D)
- 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 (if selected, skip to Section D)
- I have already obtained a Nevada business license and have a business license number assigned to me by the Nevada Secretary of State upon compliance with the provisions of NRS Chapter 76 (if selected, you must provide the requested business information and answer the Dental Auxiliaries portion below)

Name of Business: _____

Business License Number: _____

Street Address:	City:	State:	Zip Code:
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The Nevada State Board of Dental Examiners is not the arbiter of determining whether a licensee needs or receives a business license. Information about the Nevada business license and contracts can be found on the Secretary of State’s website.

DENTAL AUXILIARIES (ONLY for *DENTISTS that ALREADY HAVE a Nevada Business License*)
 Per NAC 631.045 A licensed dentist who owns a dental office or facility must, upon renewal, identify certain staff involved in infection control, and attest to their proper training and qualifications under applicable guidelines.

- Do you employ dental auxiliaries (dental hygienists, dental therapists, expanded function dental assistants, and dental assistants)?
- No → If selected, answer question (a) by selecting the reason for not having any dental auxiliaries and move to next section.
 - Yes → If selected, answer question (b) and attest to statement (c).

a) Reason: Independent Contractor Instructor Out of State/ Country I provide these services Employee of Practice Other

Other Reason: _____

b) I certify that each person listed below is so employed as a dental auxiliary:

Employee Name	Employee Title	Date of Employment

**If you have more employees that work as dental auxiliaries than lines provided above, please list them on a separate sheet of paper and attach to the application.*

F. PUBLIC HEALTH ENDORSED HYGIENISTS (for Dental Hygienists ONLY – NOT DENTISTS)

A Public Health Endorsed Dental Hygienist may practice outside the scope of NAC 631.210 and NAC 631.220 only while actively affiliated with and/or employed through a Board-approved Public Health Program. A hygienist may not exercise the expanded scope once they are not affiliated or employed with that approved program. If a Public Health Program withdraws its affiliation or employment, the hygienist’s Public Health Endorsement will become inactive (latent) until affiliation with an approved program is reestablished.

a) Do you have a Public Health Dental Hygienist Endorsement? (If No, skip to Section G) Yes No

b) Do you wish to renew your Public Health Dental Hygienist Endorsement? (If No, skip to Section G) Yes No

If yes, list the name(s) of the Public Health Programs with whom you are affiliated and/or employed. If you did not exercise the expanded scope under your Public Health Endorsement, write “N/A.”

Name of Affiliated Public Health Program	Public Health Program Address

**If you have more Public Health Programs with whom you are affiliated and/or employed than allowed in the space provided above, please list them on a separate sheet of paper and attach to application*

c) Do you supervise any dental assistants and/or expanded function dental assistants when utilizing your Public Health Endorsement? (If No, skip to question (d)) Yes No

If yes, list the name(s) of all dental assistants and expanded function dental assistants you supervised while utilizing your Public Health Endorsement:

Assistant’s Name	Title	Date Supervision Began

**If you supervise more people than lines provided above, please list their names, title, and the date you began supervising on a separate sheet of paper and attach to application.*

By signing the below, I hereby affirm and attest that all dental assistants and expanded function dental assistants whom I supervise(d) as listed above are qualified to assist in radiographic and infection control procedures pursuant to NAC 631.260.

Signature: _____ Date: _____

d) **By selecting this box**, I acknowledge that, pursuant to NAC 631.145, renewal of my Public Health Endorsement is contingent upon the Nevada State Board of Dental Examiners receiving, directly from my affiliated public health program(s), a practitioner’s report of the services I performed under the authority of my Public Health Endorsement.

G. AFFIDAVIT

1.	Have you had any claims or complaints of malpractice filed against you, any felony or misdemeanor convictions or charges brought against you, or had any professional license suspended, revoked or been subject to probation (whether by this agency or another licensing jurisdiction) during your current licensing period? <i>(If yes, provide a written statement outlining the facts made against you)</i>	<input type="checkbox"/> Yes <input type="checkbox"/> 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)? <i>(If yes, you MUST answer question (a) below):</i>	<input type="checkbox"/> Yes <input type="checkbox"/> 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? <i>(IF YOU ARE NOT IN COMPLIANCE, YOU MUST NOTIFY US IN WRITING OF YOUR NON-COMPLIANCE AND THE RELEVANT DETAILS)</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
3.	Have you failed to comply with any provision of NRS 631 or NAC 631 (Nevada governing laws)? <i>(If yes, provide a written statement outlining which laws were violated and the relevant details)</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
4.	Do you have any substance use addictions which would impair your ability to practice your dental profession pursuant to NRS 631 or NAC 631? <i>(If yes, provide a written statement outlining your addictions and the relevant details)</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
5.	Do you utilize laser radiation in the performance of your professional duties? <i>(If yes, you MUST submit certification documents with your renewal, pursuant to NAC 631.033)</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
6.	Do you inject neuromodulators that are derived from clostridium botulinum, dermal and soft tissue fillers to patients? <i>(If yes, you must submit certification documents of a Board-approved certification course in neuromodulators (derived from Clostridium botulinum) and dermal and soft tissue fillers with your renewal, pursuant to NAC 631.257)</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
7.	Do you have a valid controlled substance permit with the Nevada State Board of Pharmacy? <i>(If yes, you MUST answer question (a) and (b) below):</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
	a) Have you conducted a minimum of one self-query annually?: Date of 1 st report MM/ DD/ YYYY Date of 2 nd report: MM/ DD/ YYYY DEA No. _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
	b) <input type="checkbox"/> By selecting this box, I hereby affirm and attest that I have completed the required two (2) hours of continuing education with a recognized provider for the abuse and misuse of controlled substances. I understand that all continuing education certificates of completion issued by recognized providers must be maintained for a minimum of three (3) years and may be audited by the Board pursuant to NAC 631.177.	
8.	I attest by signing my initials that I am aware of the mandatory requirement to report child abuse and neglect in accordance with the laws of the State of Nevada.	_____ Initials
9.	I attest by signing my initials that I will self-report any unusual activity occurring during or close in time to my delivery of services (including but not limited to patient deaths, serious patient harm, any act resulting in a medical malpractice lawsuit, and any criminal arrest or conviction).	_____ Initials

By signing below, I hereby affirm and attest under penalty of perjury that I have answered the above questions truthfully, accurately, and by me personally, the licensee so named on this form and so stating 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.

Signature: _____ Date: _____

H. RENEWAL FEES

IF YOU ARE RENEWING YOUR APPLICATION PAST THE DATE AS REQUIRED PER NRS 631.330 YOU SHALL BE ASSESSED A SUSPENDED LICENSE REINSTATEMENT FEE IN ADDITION TO YOUR RENEWAL FEE

DENTIST

<input type="checkbox"/> General Dentist	\$600.00	<input type="checkbox"/> Specialty Dentist	\$600.00
<input type="checkbox"/> Restricted Geographical Dentist	\$600.00	<input type="checkbox"/> Suspended License	\$300.00

DENTAL HYGIENIST

<input type="checkbox"/> Registered Dental Hygienist	\$300.00	<input type="checkbox"/> Restricted Geographical	\$300.00
<input type="checkbox"/> Suspended License	\$300.00		

DENTAL THERAPIST

<input type="checkbox"/> Dental Therapist	\$600.00	<input type="checkbox"/> Restricted Geographical	\$600.00
<input type="checkbox"/> Suspended License	\$300.00		

EXPANDED FUNCTION DENTAL ASSISTANT

<input type="checkbox"/> EFDA	\$100.00	<input type="checkbox"/> Restricted Geographical	\$100.00
<input type="checkbox"/> Suspended License	\$120.00		

OPTIONAL REQUEST FEES

<input type="checkbox"/> Duplicate Wall Cert	\$25.00	Quantity: _____	<input type="checkbox"/> Name Change	\$25.00
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PAYMENT METHOD

Payment Method: <input type="checkbox"/> Check/Money Order (attach with application) <input type="checkbox"/> Credit*/Debit Card (credit cards will incur a 3% surcharge)		Total Amount Authorized
Name on Card:	Card Number - - -	
Card Billing Address:	Exp Date:	CVV:
Street:	City:	State: Zip:
		\$

***A 3% surcharge is assessed for credit card payments**

By signing below, I acknowledge and agree that, once payment is made, I will not be entitled to a refund of any amount, even if I change my mind about renewing my State of Nevada professional dental license. I understand that the money paid with the renewal application compensates the Board for staff time associated with processing the renewal application, which occurs whether or not I ultimately benefit from my State of Nevada professional dental license.

Signature: _____ Date: _____

You may email, mail, or drop off your completed renewal application with payment to:

Email: nsbde@dental.nv.gov

Mail/Drop Off: Nevada State Board of Dental Examiners
 Attention: Licensing Department
 2651 N Green Valley Pkwy, Ste 104
 Henderson, NV 89014