NEVADA STATE BOARD OF DENTAL EXAMINERS
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OFFICE USE ONLY	
Date Received:	
Payment Amount:	
Staff Initials:	

BIENNIAL NON-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:	☐ General Dentist	☐ Specialty Dentist	☐ Restricted Geographical
Dental Hygiene Licenses:	☐ Registered Dental Hygienist	☐ Restricted Geographical	
Dental Therapist:	☐ Dental Therapist	☐ Restricted Geographical	
Expanded Function Dental Assistant (EFDA):	☐ EFDA	☐ Restricted Geographical	
LISENCE STATUS			
License Status:	☐ Inactive	☐ Retired	☐ Disabled

B. CONTACT INFORMATION			
First Name:	Middle Name:	Last Name:	License Number:
Home Phone:	Cell Phone:	Email Address:	
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.			
Home Address:		Apt/Ste:	
City:	State:	Zip Code:	
Address Change Effective Date (if changed):	☐ 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:

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 *(for dentists that already have a Nevada Business License ONLY)*

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.*

C. NEVADA BUSINESS LICENSE REPORT AND AUXILIARIES CONTINUED

c) ☐ **By selecting this box,** I attest that each such employee has received adequate instruction in all of the following:

1) radiographic procedures,
2) current CPR training,
3) required continuing education in infection control (a minimum of four (4) hours of continuing education in infection control every two (2) years);
4) and (prior to employment) a copy of chapters 631 of NAC and NRS.

D. AFFIDAVIT

	Question	Response
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 the current licensing period? (If yes, provide a written statement outlining the facts made against you)	☐ 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 NOTIFY US IN WRITING OF YOUR NON-COMPLIANCE AND THE RELEVANT DETAILS)	☐ Yes ☐ No
3.	Have you failed to comply with any provision of NRS 631 or NAC 631 (Nevada governing laws)? (If yes, provide a written statement outlining which laws were violated and the relevant details)	☐ Yes ☐ No
4.	Are you changing your Active license status to Inactive/Retired or Disabled status? (If yes, you MUST attest to the below statement by signing your initials in the space provided):	☐ Yes ☐ No
	I hereby affirm and attest that during the time that my license was active, I completed the required hours of continuing education for my license with recognized providers. 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. In addition to the required CE hours, pursuant to NRS 631.342. I affirm that I have fulfilled a mandated four (4) hour continuing education course in "terrorism to be completed two (2) years after receiving licensure in this state.	______ 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: ______________

E. 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				
☐	Inactive Dentist	$600.00	☐ Retired/Disabled Dentist	$50.00
☐	Suspended License	$300.00		
DENTAL HYGIENIST				
☐	Inactive Registered Dental Hygienist	$50.00	☐ Retired/Disabled Dental Hygienist	$50.00
☐	Suspended License	$300.00		
DENTAL THERAPIST				
☐	Inactive Dental Therapist	$50.00	☐ Retired/Disabled Dental Therapist	$50.00
☐	Suspended License	$300.00		
EXPANDED FUNCTION DENTAL ASSISTANT				
☐	Inactive EFDA	$75.00	☐ Retired/Disabled EFDA	$50.00
☐	Suspended License	$120.00		

PAYMENT METHOD

Payment Method: ☐ Check/Money Order (attach with application)	☐ 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