



**NEVADA STATE BOARD OF DENTAL EXAMINERS**

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<u>OFFICE USE ONLY</u>	
Date Received:	_____
Payment Amount:	_____
Staff Initials:	_____

**ANNUAL LICENSE RENEWAL**

**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	

**NON-ACTIVE LICENSURE DATES FOR RENEWAL PERIOD**

Non-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:	

**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.**

**IF YOU WORK AT OR OWN MORE THAN ONE (1) OFFICE, PROVIDE ALL OTHERS ON A SEPARATE SHEET**

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. 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 <sup>st</sup> report   MM/ DD/ YYYY   Date of 2 <sup>nd</sup> report:   MM/ DD/ YYYY   DEA No. _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
b) <input type="checkbox"/> <b>By selecting this box</b> , 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: \_\_\_\_\_

**G. RENEWAL FEES**

**YOU MAY NOT RENEW YOUR APPLICATION PAST THE EXPIRATION DATE. SHOULD YOUR LICENSE EXPIRE, YOU MUST SUBMIT A NEW APPLICATION.**

**DENTIST**

<input type="checkbox"/> Limited Dentist	\$200.00	<input type="checkbox"/> Restricted Dentist	\$100.00
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**DENTAL HYGIENIST**

<input type="checkbox"/> Limited Registered Dental Hygienist	\$200.00	<input type="checkbox"/> Restricted Dental Hygienist	\$200.00
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**DENTAL THERAPIST**

<input type="checkbox"/> Limited Dental Therapist	\$TBA	<input type="checkbox"/> Restricted Dental Therapist	\$TBA
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**EXPANDED FUNCTION DENTAL ASSISTANT**

<input type="checkbox"/> Expanded Function Dental Assistant	\$TBA
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**OPTIONAL REQUEST FEES**

<input type="checkbox"/> Duplicate Wall Cert	\$25.00	Quantity: _____
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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)		<b>Total Amount Authorized</b>
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: \_\_\_\_\_