

**NEVADA STATE BOARD OF DENTAL EXAMINERS**

2651 N Green Valley Parkway, Suite 104,

Henderson, Nevada 89014

[nsbde@dental.nv.gov](mailto:nsbde@dental.nv.gov)

Phone(702) 486-7044 | (800) DDS-EXAM | Fax (702)486-7046

**OFFICE USE ONLY**

Date Received: \_\_\_\_\_

Payment Amount: \_\_\_\_\_

Staff Initials: \_\_\_\_\_

**ANNUAL ACTIVE LICENSE RENEWAL**

**RENEWAL OF YOUR NEVADA DENTAL LICENSE IS COMPLETE UPON THE BOARD'S PHYSICAL RECEIPT OF ALL REQUIRED INFORMATION NO LATER THAN THE DATE REQUIRED PER NRS 631.271. INCOMPLETE OR ILLEGIBLE RENEWAL APPLICATIONS WILL NOT BE PROCESSED.**

**A. LICENSE TYPE**

Dentistry Licenses:	<input type="checkbox"/> Restricted License	<input type="checkbox"/> Limited License Resident	<input type="checkbox"/> Limited License Instructor
	<input type="checkbox"/> Limited License Supervising CE		
Dental Hygiene Licenses:	<input type="checkbox"/> Limited License Instructor		
Dental Therapist:	<input type="checkbox"/> Limited License		
Expanded Function Dental Assistant (EFDA):	<input type="checkbox"/> Limited License		
<b>ACTIVE LICENSURE DATES</b>			
Active Licensure Date:	Begin: MM/ DD/ YYYY		End: MM/ DD/ YYYY

**B. CONTACT INFORMATION**

First Name:	Middle Name:	Last Name:	License Number:	
<p><b>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 via the Address Change Form (or updated online) within thirty (30) days of such change. Please complete and submit the Address Change Form located on the front page of the NSBDE website. All addresses are treated individually.</b></p> <p><b>IF YOU WORK AT OR OWN MORE THAN ONE (1) OFFICE, LIST OTHERS ON A SEPARATE SHEET INCLUDING THE LICENSED DENTIST NAME.</b></p>				
Name/Practice Name/DBA:		Office Address:		
City:	State:	Zip Code:	Office Phone:	Office Fax:
<input type="checkbox"/> Mailing Address is the same as Practice Address				
Home Address:		Apt/Ste:	Email Address:	
City:	State:	Zip Code:	Office Phone:	Office Fax:
<input type="checkbox"/> Mailing Address is the same as Home Address				

## C. REPORT OF EXISTENCE OF NEVADA BUSINESS LICENSE – NRS 622.240

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

**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
- ☐ 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 and contracts can be found on the Secretary of State's website at: <https://www.nvsilverflume.gov/home>.**

## D. CPR CERTIFICATION

New CPR dates:

Begin: MM/ DD/ YYYY

End: MM/ DD/ YYYY

- ☐ **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 (3) years and may be audited by the Board pursuant to NAC 631.177

## E. CONTINUING EDUCATION

**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 held 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 the mandated four (4) hour continuing education course in "terrorism" to be completed within two (2) years of receiving licensure in this state and two (2) hour continuing education course in infection control.

*Please note 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. 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.*

## F. DENTAL AUXILIARIES (Dental Assistants, Dental Hygienists, Dental Therapists, Radiographic Techs and/or Sterilization Personnel)

Do you employ dental auxiliaries?

- No ☐ If no, please answer question (a) by selecting the reason for not having any dental auxiliaries and move to next section
- Yes ☐ If yes, please answer question (b) and attest check box

a)	Reason:	Independent Contractor <input type="checkbox"/>	Instructor <input type="checkbox"/>	Out of State/ Country <input type="checkbox"/>	I provide these services <input type="checkbox"/>	Employee of Practice <input type="checkbox"/>
b)	I certify that each person listed below is so employed as a dental auxiliary:					
		Employee Name	Employee Title	Date Began Assisting		
<i>*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 application</i>						
<input type="checkbox"/>	By selecting this box, I attest that each such employee has received: (a) Adequate instruction concerning radiographic procedures and is qualified to operate radiographic equipment as required pursuant to subsection 3 of NAC 459.552; (b) Training in CPR at least every two (2) years while employed. (c) A minimum of four (4) hours of continuing education in infection control every two (2) years while so employed; & (d) Before beginning such employment, a copy of chapter 631 of NAC and chapter 631 of NRS in paper or electronic format.					

## G. AFFIDAVIT

1.	I hereby certify the following to the Nevada State Board of Dental Examiners for the period my license was active from:		
	Begin:	MM/ DD/ YYYY	End: MM/ DD/ YYYY
2.	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 your current licensing period? <span style="color: red;">(If yes, provide a written statement outlining the facts)</span>		Yes <input type="checkbox"/> No <input type="checkbox"/>
3.	Are you subject to court order for the support of one or more children (i.e. do you have a child support order?)? <span style="color: red;">(If yes, you MUST answer question (a) below):</span>		Yes <input type="checkbox"/> No <input type="checkbox"/>
	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? <span style="color: red;">(IF YOU ARE NOT IN COMPLIANCE, YOU MUST PROVIDE WRITTEN NOTIFICATION)</span>		Yes <input type="checkbox"/> No <input type="checkbox"/>
4.	Have you complied with the provisions of NRS 631 and NAC 631 (Nevada Governing Laws)?		Yes <input type="checkbox"/> No <input type="checkbox"/>
5.	Do you have any addictions which would impair your practice of dentistry pursuant to NRS 631 or NAC 631?		Yes <input type="checkbox"/> No <input type="checkbox"/>
6.	Do you utilize laser radiation in the performance of your practice of dentistry? <span style="color: red;">(If yes, you MUST answer question (a) below):</span>		Yes <input type="checkbox"/> No <input type="checkbox"/>
	a) Have you submitted appropriate certification to the Board pursuant to NAC 631.933 and NAC 631.035?		Yes <input type="checkbox"/> No <input type="checkbox"/>

7.	Do you inject neuromodulators that are derived from clostridium botulinum, dermal and soft tissue fillers to your patients? <b>(If yes, you MUST answer question (a) below):</b>	Yes <input type="checkbox"/> No <input type="checkbox"/>
	a) Have you completed a board approved certification course to inject a neuromodulator that is derived from clostridium botulinum, dermal and soft tissue fillers pursuant to NAC 631.257? <b>(If yes, you must submit certification documents with renewal)</b>	Yes <input type="checkbox"/> No <input type="checkbox"/>
8.	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 <input type="checkbox"/> No <input type="checkbox"/>
9.	I attest by checking "Yes", I will self report any anomaly occurrence during the practice of dentistry.	Yes <input type="checkbox"/> No <input type="checkbox"/>
10.	Do you have a valid controlled substance permit with the Nevada State Board of Pharmacy? <b>(If yes, you MUST answer question (a) and (b) below):</b>	Yes <input type="checkbox"/> No <input type="checkbox"/>
	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. _____	Yes <input type="checkbox"/> No <input type="checkbox"/>
	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.	

H. RENEWAL FEES			
<b>IF YOU ARE RENEWING YOUR APPLICATION PAST THE DATE AS REQUIRED PER NRS 631.330 YOU SHALL BE ASSESSED A SUSPENDED LICENSE FEE IN ADDITION TO YOUR RENEWAL FEE</b>			
<b>DENTIST</b>			
<input type="checkbox"/> Limited License Dentist	\$200.00	<input type="checkbox"/> Restricted License	\$100.00
<input type="checkbox"/> <b>Suspended License</b>	<b>\$300.00</b>		
<b>DENTAL HYGIENIST</b>			
<input type="checkbox"/> Limited License	\$200.00	<input type="checkbox"/> <b>Suspended License</b>	<b>\$300.00</b>
<b>DENTAL THERAPIST</b>			
<input type="checkbox"/> Limited License	\$200.00	<input type="checkbox"/> <b>Suspended License</b>	<b>\$300.00</b>
<b>EXPANDED FUNCTION DENTAL ASSISTANT</b>			
<input type="checkbox"/> Limited License	\$200.00	<input type="checkbox"/> <b>Suspended License</b>	<b>\$300.00</b>
<b>OPTIONAL REQUEST FEES</b>			
<input type="checkbox"/> Duplicate Wall Cert   \$25.00   Quantity: _____	<input type="checkbox"/> Name Change   \$25.00		

By signing below, I hereby affirm and attest, that I have answered the above questions truthfully, accurately, and by my 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:

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## 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

## CREDIT CARD

## AUTHORIZATION FORM

<b>Name of Person Requesting:</b>		<b>Mailing Address</b> (where to mail document requested):	
<b>Telephone Number:</b> ( ) -			
<b>NV License Number:</b>	<input type="checkbox"/> Dental <input type="checkbox"/> Dental Hygiene	<b>Suite No.:</b>	<b>City:</b>
		<b>State:</b>	<b>Zip Code:</b>

<b>Dental Licensure Application Fees</b>
<input type="checkbox"/> License by Exam – WREB (\$1200)
<input type="checkbox"/> License by Exam – ADEX (\$1200)
<input type="checkbox"/> License by Endorsement (\$1200)
<input type="checkbox"/> Specialty License by Credential (\$1200)
<input type="checkbox"/> Geographically Restricted (\$600)
<input type="checkbox"/> Limited License – Faculty / Resident (\$125)
<input type="checkbox"/> Limited Licensed for Supervision (\$100)
<input type="checkbox"/> Restricted License (\$125)
<input type="checkbox"/> Military by Reciprocity (\$1200)
<input type="checkbox"/> Specialty License by App [NV licensed Dentist only] (\$125) (If applying for a general dental license & specialty license concurrently, application fee will be \$1325)

<b>Dental Anesthesia Permit Fees</b>
<b>Permit Application:</b> \$ (choose below): <input type="checkbox"/> General Anesthesia Administrator Permit (\$750) <input type="checkbox"/> Moderate Sedation Administrator Permit (\$750) <input type="checkbox"/> Pediatric Moderate Sedation Administrator Permit (\$750) <input type="checkbox"/> Site Permit (\$500)
<b>Renewal:</b> \$   <b>Permit No.:</b> (choose one): <input type="checkbox"/> General Anesthesia   <input type="checkbox"/> Moderate Sedation <input type="checkbox"/> Site Permit
<b>Permit Re-Inspection:</b> \$ (choose one): <input type="checkbox"/> Administration Permit Re-inspection (\$500) <input type="checkbox"/> Site Permit Re-inspection (\$350)

<b>Infection Control Inspection</b>
<input type="checkbox"/> Initial Infection Control Inspection (\$250)

<b>Miscellaneous Fees</b>	
<input type="checkbox"/> NRS Booklet (\$3) x	<input type="checkbox"/> NAC Booklet (\$3) x
<input type="checkbox"/> Returned Check Fee (\$25)	<input type="checkbox"/> Change of Address Fine (\$50)
<input type="checkbox"/> Civil Penalty \$	<input type="checkbox"/> Investigation Costs \$
<input type="checkbox"/> Continuing Education Provider Fee: (1 <sup>st</sup> Hour = \$150 / each additional hour = \$50) Total Hours: Total Fee: \$	

<b>Dental Hygiene Licensure Application Fees</b>
<input type="checkbox"/> Licensure by Exam – WREB (\$600)
<input type="checkbox"/> Licensure by Exam – ADEX (\$600)
<input type="checkbox"/> Licensure by Endorsement (\$600)
<input type="checkbox"/> Geographically Restricted (\$150)
<input type="checkbox"/> Limited License (\$125)
<input type="checkbox"/> Military by Reciprocity (\$600)

<b>Dental Hygiene Permit Application Fees</b>
<input type="checkbox"/> Local Anesthesia Permit (\$25)
<input type="checkbox"/> Nitrous Oxide Permit (\$25)

<b>License Renewal Fees</b>
<input type="checkbox"/> Active Status \$
<input type="checkbox"/> Inactive Status \$
<input type="checkbox"/> Retired Status \$
<input type="checkbox"/> Disabled Status \$
<input type="checkbox"/> Limited License \$
<input type="checkbox"/> Restricted License \$
<input type="checkbox"/> License Reactivation (\$300)

<b>Reinstatement of License Fees</b>
<input type="checkbox"/> Suspended (\$300)   <input type="checkbox"/> Revoked (\$500)

<b>Request for Duplicate Certificate Fees</b>
<input type="checkbox"/> Duplicate Wall Certificate (\$25)
<input type="checkbox"/> Name Change Fee - New Wall Certificate (\$25)
<input type="checkbox"/> Duplicate DH Local Anesthesia/N2O Permit (\$25)
<input type="checkbox"/> Duplicate Dental Anesthesia Permit (\$25 each) (Select below): <input type="radio"/> GA Admin. Permit No.: <input type="radio"/> Mod. Sedation Admin. Permit No.: <input type="radio"/> Peds Mod. Sed Admin. Permit No.: <input type="radio"/> Site Permit No.:

<b>Other:</b>

<b>Name on Credit Card:</b>	<b>Method of Payment:</b> <input type="checkbox"/> MasterCard   <input type="checkbox"/> Visa   <input type="checkbox"/> Discover	<b>Total Amount Authorized:</b> \$
<b>Credit Card Billing Address:</b>	<b>Credit Card Number:</b>	
<b>Ste. No.:</b> <b>City:</b>	<b>Exp. Date:</b> -	
<b>State:</b> <b>Zip Code:</b>	<b>Security Code:</b>	

**Purchaser's Signature:** **Date:** / /

**\*\* THERE IS A 7 to 15 BUSINESS DAY PROCESSING PERIOD FOR ALL REQUESTS\*\***

Form accepted by mail or fax (see the top of the page), or email PDF to [nsbde@dental.nv.gov](mailto:nsbde@dental.nv.gov)