



NEVADA STATE BOARD OF DENTAL EXAMINERS

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Henderson, Nevada 89014

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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		
ACTIVE LICENSURE DATES			
Active Licensure Date:	Begin: MM/ DD/ YYYY	End: MM/ DD/ YYYY	

B. CONTACT INFORMATION

First Name:	Middle Name:	Last Name:	License Number:
<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 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.</p> <p>IF YOU WORK AT OR OWN MORE THAN ONE (1) OFFICE, LIST OTHERS ON A SEPARATE SHEET INCLUDING THE LICENSED DENTIST NAME.</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**

7. Do you inject neuromodulators that are derived from clostridium botulinum, dermal and soft tissue fillers to your patients? (If yes, you MUST answer question (a) below):	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? (If yes, you must submit certification documents with renewal)	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? (If yes, you MUST answer question (a) and (b) below):	Yes <input type="checkbox"/> No <input type="checkbox"/>
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. _____	Yes <input type="checkbox"/> No <input type="checkbox"/>
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.	

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 FEE IN ADDITION TO YOUR RENEWAL FEE			
DENTIST			
<input type="checkbox"/> Limited License Dentist	\$200.00	<input type="checkbox"/> Restricted License	\$100.00
<input type="checkbox"/> Suspended License	\$300.00		
DENTAL HYGIENIST			
<input type="checkbox"/> Limited License	\$200.00	<input type="checkbox"/> Suspended License	\$300.00
DENTAL THERAPIST			
<input type="checkbox"/> Limited License	\$200.00	<input type="checkbox"/> Suspended License	\$300.00
EXPANDED FUNCTION DENTAL ASSISTANT			
<input type="checkbox"/> Limited License	\$200.00	<input type="checkbox"/> Suspended License	\$300.00
OPTIONAL REQUEST FEES			
<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:
