NEVADA STATE BOARD OF DENTAL EXAMINERS
2651 N Green Valley Parkway, Suite 104,
Henderson, Nevada 89014
nsbde@dental.nv.gov
Phone (702) 486-7044 | (800) DDS-EXAM | Fax (702)486-7046

OFFICE USE ONLY	
Date Received:	_____
Payment Amount:	_____
Staff Initials:	_____

BIENNIAL ACTIVE LICENSE RENEWAL July 1, 2025 – June 30, 2027

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 631.330. 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	

ACTIVE LICENSURE DATES

Active Licensure Dates:	Begin: MM/ DD/ YYYY	End: MM/ DD/ YYYY

B. CONTACT INFORMATION

First Name:	Middle Name:	Last Name:	License Number:

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.

IF YOU WORK AT OR OWN MORE THAN ONE (1) OFFICE, LIST OTHERS ON A SEPARATE SHEET INCLUDING THE LICENSED DENTIST NAME.

Name/Practice Name/DBA:		Office Address:		
City:	State:	Zip Code:	Office Phone:	Office Fax:

☐ Mailing Address is the same as Practice Address

Home Address:		Apt/Ste:	Email Address:	
City:	State:	Zip Code:	Office Phone:	Office Fax:

☐ 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 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 within two (2) years of receiving licensure in this state and four (4) 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 of receiving licensure in this state. The state-mandated course is part of your required CE hours. 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	☐	Instructor	☐	Out of State/ Country	☐	I provide these services	☐	Employee of Practice ☐

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

Employee Name	Employee Title	Date Began Assisting

**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*

☐ 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. PUBLIC HEALTH *(for Public Health Dental Hygienists ONLY – NOT DENTISTS)*

Do you wish to renew your Public Health Dental Hygienist Endorsement? Yes ☐ No ☐

For reporting purposes, please provide the total number of each procedure provided/completed through your Public Health Endorsement (If you did not provide a particular service/procedure, enter the number zero-0- on the corresponding line):

Screening/Assessments ____ Sealants ____ Child Prophy ____ Adult Prophy ____

X-rays ____ Adult Root Planning ____ Fluoride Treatment ____ Other (OHI, OHP, etc) ____

☐ **By selecting this box,** I hereby affirm and attest that I hold current malpractice insurance coverage for services performed through all public health programs.

Pursuant to NAC 631.260, I certify that all persons I supervise (listed below), except for licensed dental hygienists, to assist in radiographic and infection control procedures, are qualified to assist in such procedures*

Employee Name	Employee Title	Date Began Assisting

**If you have more employees you supervise than lines provided above, please list them on a separate sheet of paper and attach to application*

H. 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? (If yes, provide a written statement outlining the facts) Yes ☐ No ☐

3. 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 PROVIDE WRITTEN NOTIFICATION) Yes ☐ No ☐

4. Have you complied with the provisions of NRS 631 and NAC 631 (Nevada Governing Laws)? Yes ☐ No ☐

5. Do you have any addictions which would impair your practice of dentistry pursuant to NRS 631 or NAC 631? Yes ☐ No ☐

6. Do you utilize laser radiation in the performance of your practice of dentistry? (If yes, you MUST answer question (a) below): Yes ☐ No ☐

   a) Have you submitted appropriate certification to the Board pursuant to NAC 631.933 and NAC 631.035? Yes ☐ No ☐

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 ☐ No ☐

   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 ☐ No ☐

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 ☐ No ☐

9. I attest by checking "Yes", I will self report any anomaly occurrence during the practice of dentistry. Yes ☐ No ☐

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 ☐ No ☐

    a) Have you conducted a minimum of one self-query annually: Yes ☐ No ☐

    Date of 1st report MM/ DD/ YYYY Date of 2nd report: MM/ DD/ YYYY DEA No. _____

    b) ☐ **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.

CONTINUE TO PAGE 5 AND SIGN AND ATTEST TO THE APPLICATION TO COMPLETE APPLICATION. APPLICATIONS THAT ARE NOT SIGNED ARE NOT COMPLETE AND WILL NEED TO BE RESUBMITTED.

I. 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					
☐	General Dentist	$600.00	☐	Specialty Dentist	$600.00
☐	Restricted Geographical Dentist	$600.00	☐	Suspended License	$300.00
DENTAL HYGIENIST					
☐	Registered Dental Hygienist	$300.00	☐	Restricted Geographical	$300.00
☐	Suspended License	$300.00			
DENTAL THERAPIST					
☐	Dental Therapist	$600.00	☐	Restricted Geographical	$600.00
☐	Suspended License	$300.00			
EXPANDED FUNCTION DENTAL ASSISTANT					
☐	EFDA	$600.00	☐	Restricted Geographical	$600.00
☐	Suspended License	$300.00			
OPTIONAL REQUEST FEES					
☐	Duplicate Wall Cert $25.00 Quantity: _____		☐	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:

_____ _____

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

Name of Person Requesting:	**Mailing Address (where to mail document requested):**
Telephone Number: ( )_____-_____	Suite No.:_____ City: _____
NV License Number: ☐ Dental ☐ Dental Hygiene	State:_____ Zip Code: _____

Dental Licensure Application Fees

- ☐ License by Exam – WREB ($1200)
- ☐ License by Exam – ADEX ($1200)
- ☐ License by Endorsement ($1200)
- ☐ Specialty License by Credential ($1200)
- ☐ Geographically Restricted ($600)
- ☐ Limited License – Faculty / Resident ($125)
- ☐ Limited Licensed for Supervision ($100)
- ☐ Restricted License ($125)
- ☐ Military by Reciprocity ($1200)
- ☐ Specialty License by App [NV licensed Dentist only] ($125)

(If applying for a general dental license & specialty license concurrently, application fee will be $1325)

Dental Anesthesia Permit Fees

Permit Application: $_____ (choose below):
- ☐ General Anesthesia Administrator Permit ($750)
- ☐ Moderate Sedation Administrator Permit ($750)
- ☐ Pediatric Moderate Sedation Administrator Permit ($750)
- ☐ Site Permit ($500)

Renewal: $_____ | Permit No.: _____
(choose one): ☐ General Anesthesia | ☐ Moderate Sedation ☐ Site Permit

Permit Re-Inspection: $_____
(choose one): ☐ Administration Permit Re-inspection ($500) ☐ Site Permit Re-inspection ($350)

Infection Control Inspection

- ☐ Initial Infection Control Inspection ($250)

Miscellaneous Fees

☐ NRS Booklet ($3) x _____	☐ NAC Booklet ($3) x _____
☐ Returned Check Fee ($25)	☐ Change of Address Fine ($50)
☐ Civil Penalty $_____	☐ Investigation Costs $ _____

☐ Continuing Education Provider Fee:
(1st Hour = $150 / each additional hour = $50)
Total Hours:_____ Total Fee: $ _____

Dental Hygiene Licensure Application Fees

- ☐ Licensure by Exam – WREB ($600)
- ☐ Licensure by Exam – ADEX ($600)
- ☐ Licensure by Endorsement ($600)
- ☐ Geographically Restricted ($150)
- ☐ Limited License ($125)
- ☐ Military by Reciprocity ($600)

Dental Hygiene Permit Application Fees

- ☐ Local Anesthesia Permit ($25)
- ☐ Nitrous Oxide Permit ($25)

License Renewal Fees

- ☐ Active Status $ _____
- ☐ Inactive Status $ _____
- ☐ Retired Status $ _____
- ☐ Disabled Status $ _____
- ☐ Limited License $ _____
- ☐ Restricted License $ _____
- ☐ License Reactivation ($300)

Reinstatement of License Fees

☐ Suspended ($300) | ☐ Revoked ($500)

Request for Duplicate Certificate Fees

- ☐ Duplicate Wall Certificate ($25)
- ☐ Name Change Fee - New Wall Certificate ($25)
- ☐ Duplicate DH Local Anesthesia/N2O Permit ($25)
- ☐ Duplicate Dental Anesthesia Permit ($25 each)

(Select below):
- ○ GA Admin. Permit No.:_____
- ○ Mod. Sedation Admin. Permit No.: _____
- ○ Peds Mod. Sed Admin. Permit No.: _____
- ○ Site Permit No.:_____

Other: _____

Name on Credit Card:	**Method of Payment:** ☐ MasterCard | ☐ Visa | ☐ Discover	**Total Amount Authorized:** $ _____
Credit Card Billing Address: _____ Ste. No.:_____ City: _____ State:_____ Zip Code: _____	**Credit Card Number:** _____-_____-_____-_____ Exp. Date:_____- _____ Security Code:_____	

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