



Nevada State Board of Dental Examiners

6010 S. Rainbow Blvd., Bldg. A, Ste. 1

Las Vegas, NV 89118

(702) 486-7044 • (800) DDS-EXAM • Fax (702) 486-7046

FACT SHEET

APPLICANTS FOR LICENSURE BY ENDORSEMENT

Thank you for your interest in applying for licensure by endorsement in the State of Nevada. Senate Bill 69 was enacted by the Legislature and became law in June 2017. The statute under Chapter 622 states:

- 1. Except as otherwise provided by specific statute relating to the issuance of a license by endorsement, a regulatory body shall adopt regulations providing for the issuance of a license by endorsement to engage in an occupation or profession in this State to any natural person who:*
 - (a) Holds a corresponding valid and unrestricted license to engage in that occupation or profession in the District of Columbia or any state or territory of the United States;*
 - (b) Possesses qualifications that are substantially similar to the qualifications required for issuance of a license to engage in that occupation or profession in this State; and*
 - (c) Satisfies the requirements of this section and the regulations adopted pursuant thereto.*
- 2. The regulations adopted pursuant to subsection 1 must not allow the issuance of a license by endorsement to engage in an occupation or profession in this State to a natural person unless such a person:*
 - (a) Is a citizen of the United States or otherwise has the legal right to work in the United States;*
 - (b) Has not been disciplined by the corresponding regulatory authority of the District of Columbia or any state or territory in which the applicant currently holds or has held a license to engage in an occupation or profession;*
 - (c) Has not been held civilly or criminally liable in the District of Columbia or any state or territory of the United States for misconduct relating to his or her occupation or profession;*
 - (d) Has not had a license to engage in an occupation or profession suspended or revoked in the District of Columbia or any state or territory of the United States;*
 - (e) Has not been refused a license to engage in an occupation or profession in the District of Columbia or any state or territory of the United States for any reason;*
 - (f) Does not have pending any disciplinary action concerning his or her license to engage in an occupation or profession in the District of Columbia or any state or territory of the United States;*
 - (g) Pays any applicable fees for the issuance of a license that are otherwise required for a natural person to obtain a license in this State;*
 - (h) Submits to the regulatory body a complete set of his or her fingerprints and written permission authorizing the regulatory body to forward the fingerprints to the Central Repository for Nevada Records of Criminal History for submission to the Federal Bureau of Investigation for its report or proof that the applicant has previously passed a comparable criminal background check; and*
 - (i) Submits to the regulatory body the statement required by NRS 425.520.*

3. A regulatory body may, by regulation, require an applicant for issuance of a license by endorsement to engage in an occupation or profession in this State to submit with his or her application:

(a) Proof satisfactory to the regulatory body that the applicant:

(1) Has achieved a passing score on a nationally recognized, nationally accredited or nationally certified examination or other examination approved by the regulatory body;

(2) Has completed the requirements of an appropriate vocational, academic or professional program of study in the occupation or profession for which the applicant is seeking a license by endorsement in this State;

(3) Has engaged in the occupation or profession for which the applicant is seeking a license by endorsement in this State pursuant to the applicant's existing licensure for the period determined by the regulatory body preceding the date of the application; and

(4) Possesses a sufficient degree of competency in the occupation or profession for which he or she is seeking licensure by endorsement in this State;

(b) An affidavit stating that the information contained in the application and any accompanying material is true and complete; and

(c) Any other information required by the regulatory body.

On May 16, 2018, the Board amended NAC 631.030 to include documentation and information that is required for an applicant applying for licensure by endorsement:

2(b) A certificate granted by a nationally recognized, nationally accredited or nationally certified examination or other examination approved by the Board which proves that the applicant has achieved a passing score on such an examination; and

(c) Proof that the applicant has actively practiced dentistry or dental hygiene for the 5 years immediately preceding the date of submission of the application.

The information listed below explains the application process.

Jurisprudence Examination/Fingerprints

Written confirmation of the receipt of your application and application fee will be sent to you via US Mail, along with the on-line jurisprudence examination registration information and the fingerprint materials, within twenty one (21) business days from the date the application is received.

NOTE: Pursuant to the laws of the State of Nevada, you are required to utilize the official fingerprint cards and documents approved by the Nevada Department of Public Safety. The Board is unable to accept any other fingerprint documents. To avoid additional expense, please wait to receive the fingerprint package from the Board.

NOTE: Each applicant shall successfully pass the jurisprudence examination which is based on the contents and interpretation of Chapter 631 and the regulations of the Board. In addition, the applicant must file all required documents to the Board office before an application will be deemed complete and ready for review by the Board's Secretary-Treasurer.

Checklist

The Board has provided a checklist of the items you will be responsible for requesting and/or submitting to the Board. Please be advised, National Board Scores, Certified Copies of School Transcripts and Verification of Licensure documents if hand delivered must be in sealed envelopes.

Application Review:

Upon receipt of all required documentation, your application for licensure will be reviewed by the Secretary Treasurer to ensure compliance (NAC 631.050). If the application is found to be in compliance the Secretary Treasurer shall instruct the Executive Director to issue the license.

Activation/Renewal of License:

Upon approval of your application for licensure by the Board, you will receive an approval packet to include, but not limited to, the license number assigned, the activation/renewal form to include fee amounts specific for your licensure type (prorated), information regarding, business license, continuing education requirements, duties delegable to dental assistants, State Board of Pharmacy regarding permits for controlled substances and the Prescription Monitoring Program access information.



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APPLICANT'S CHECKLIST FOR LICENSURE BY ENDORSEMENT

(List of items to be completed by you)

- _____ **Complete Application**
- _____ **Application Fee**
- _____ **2 x 2 color photo attached to the application**
- _____ **Original Self Query report from the National Practitioners Data Bank (NPDB)**
(See instructions included with the application)
- _____ **Certified Transcript from Dental/Dental Hygiene School (must have degree posted)**
- _____ **National Board Scores (request through the Joint Commission at www.ada.org/dentpin)**
- _____ **Certified score reports of ALL clinical examinations you participated in as a candidate**
(Please have these certified certificates mailed directly to the Board office)
- _____ **Verification of licensure letters from ALL states you are licensed, regardless of license status**
(Please have these letters mailed directly to the Board office)
- _____ **Copy of front and back of current CPR card (online courses ARE NOT acceptable)**
- _____ **Copy of Citizenship Documents**
(U.S. citizens – State birth certificate, U.S. passport or copy of naturalization certificate)
(Non-U.S. citizens – copy of legal document which allows you to remain and work in the U.S. including, but not limited to, permanent resident card, employment authorization card. etc.)
- _____ **Complete on-line jurisprudence examination**
(Registration provided upon receipt of application; results are automatically emailed to the Board office)
- _____ **Completed Fingerprint Background Waiver, ID Verification Form and 2 Fingerprints Cards***
(Provided with the jurisprudence information upon receipt of application)

*Pursuant to the laws of the State of Nevada, you are required to utilize the official fingerprint cards and documents approved by the Nevada Department of Public Safety. The Board is unable to accept any other fingerprint documents. To avoid additional expense, wait to receive the fingerprint package from the Board.

NOTE: When the Board office has received the completed application, applicable application fee and all required documents as set forth in NAC 631.030, your application will be reviewed by the Secretary-Treasurer for the Board. Upon review by the Secretary-Treasurer and having met all requirements, the Secretary-Treasurer shall instruct the Executive Director to issue the license.

IF HAND-DELIVERING ANY ITEMS NOTED ABOVE, THE MATERIALS MUST BE IN SEALED ENVELOPE



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2" x 2" color photo of
applicant taken
within the last 6
months must be
affixed to this space.

I hereby make application for Nevada Dental licensure by: (Please check one below)

Licensure by ADEX Exam (NRS 631.240): \$1200 <input type="checkbox"/>	Licensure by WREB Exam (NRS 631.240): \$1200 <input type="checkbox"/>		
Licensure by Credential (NRS 631.255): \$1200 (Please select specialty below)	Indicate Specialty: Board Eligible <input type="checkbox"/> Diplomate <input type="checkbox"/>		
Orthodontia <input type="checkbox"/>	Prosthodontia <input type="checkbox"/>	O & M Pathology <input type="checkbox"/>	
Endodontia <input type="checkbox"/>	Pediatric Dentistry <input type="checkbox"/>	O & M Radiology <input type="checkbox"/>	
Periodontia <input type="checkbox"/>	Public Health Dentist <input type="checkbox"/>	O & M Surgery <input type="checkbox"/>	
Limited Licensure (NRS 631.271): \$125	Restricted Geographical (NRS 631.274): \$600		
Resident: <input type="checkbox"/>	Instructor: <input type="checkbox"/>	Underserved County(ies): <input type="checkbox"/>	FQHC or Non-Profit: <input type="checkbox"/>
<u>Indicate Residency Program:</u>	<u>Indicate Instructor Facility:</u>	<u>Indicate County(ies)</u>	<u>Indicate FQHC Facility or Non Profit</u>

Military by Reciprocity/Credential: \$1200.00 <input type="checkbox"/>	License by Endorsement: \$1200 <input type="checkbox"/>
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NOTE: An application is considered complete when the application, all required documents, background information, and fees are on file with the Board office. APPLICATION FEES MUST BE PAID IN ADVANCE AND MAY NOT BE REFUNDED PURSUANT TO NEVADA REVISED STATUTE (NRS) 631.345.

Please type or print legibly. All questions must be answered. If additional space is needed, attach a separate sheet identifying additional information by Section number. Applicants acknowledge they have a continuing responsibility to update all information contained in this application until such time as the Board takes final action on this application. Failure of an applicant to update the information prior to final action of the Board is grounds for subsequent disciplinary action.

Last:	First:	Middle:	Suffix:
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Soc. Security #:	Age:	Male <input type="checkbox"/>	Female <input type="checkbox"/>	Birthdate:	Birthplace (City, County, State, & Country):
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Have you ever been known by any other name? Yes ☐ No ☐

If yes, state in full every other name by which you have been known, the reason therefore, and the inclusive dates so known:

If a married woman, state maiden name:

If a name change was made by court order, attach a CERTIFIED COPY of the court order.

Are you a U.S. born citizen? Yes ☐ No ☐

If no, are you naturalized? Yes ☐ No ☐

If yes, naturalization #	Naturalization Date:	Place:
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If no, were you born abroad of US citizens? Yes ☐ No ☐

If no, are you a legal resident? Yes ☐ No ☐

Is your application for naturalization pending? Yes ☐ No ☐

Date of Application:	Place:
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You must submit appropriate proof of Citizenship or legal documentation for lawful entitlement to remain in the U.S. and work in the U.S.

(A) HOME ADDRESS & PREVIOUS ADDRESS HISTORY			
Current Home Address:	City:	State:	Zip code:
Mailing Address: This is the address that all correspondence from NSBDE will be mailed. <input style="float: right;" type="checkbox"/>			
If same as current home address please check box.			
Mailing Address (If different):	City:	State:	Zip Code:
Telephone Residence:	Telephone Cell:	Email address:	

(B) PREVIOUS STREET ADDRESS			
List all home addresses for the past seven (7) years. If you cannot recall certain information please indicate cannot recall. Do not leave blank. Please be sure that if you were in school you have a home address listed in the same state you went to school. (Please add additional pages as needed)			
1. Address :	City:	State:	Zip Code:
County:	Dates: to		
2. Address :	City:	State:	Zip Code:
County:	Dates: to		
3. Address :	City:	State:	Zip Code:
County:	Dates: to		
4. Address :	City:	State:	Zip Code:
County:	Dates: to		
5. Address :	City:	State:	Zip Code:
County:	Dates: to		
6. Address :	City:	State:	Zip Code:
County:	Dates: to		
7. Address :	City:	State:	Zip Code:
County:	Dates: to		
8. Address :	City:	State:	Zip Code:
County:	Dates: to		
9. Address :	City:	State:	Zip Code:
County:	Dates: to		
10. Address :	City:	State:	Zip Code:
County:	Dates: to		

(C) MILITARY SERVICEHave you ever served in the military? *(if yes, you must answer the questions below)*Yes ☐ No ☐

Date of Service: From _____ to _____		Military Occupation Specialty/Specialties:	
Branch of Service:	Army/Army Reserve	<input type="checkbox"/>	Marine Corps/Marine Corps Reserve <input type="checkbox"/>
	Navy/Navy Reserve	<input type="checkbox"/>	Air Force/ Air force Reserve <input type="checkbox"/>
	Coast Guard/ Coast Guard Reserve	<input type="checkbox"/>	National Guard <input type="checkbox"/>
Date of Service: From _____ to _____		Military Occupation Specialty/Specialties:	
Branch of Service:	Army/Army Reserve	<input type="checkbox"/>	Marine Corps/Marine Corps Reserve <input type="checkbox"/>
	Navy/Navy Reserve	<input type="checkbox"/>	Air Force/ Air force Reserve <input type="checkbox"/>
	Coast Guard/ Coast Guard Reserve	<input type="checkbox"/>	National Guard <input type="checkbox"/>

(D) EDUCATION & CERTIFICATIONS

Doctoral:	Post Doctoral:
University/ College:	University/ College:
City:	City:
State:	State:
Years Attended: (month/year) _____ to _____	Years Attended: (month/year) _____ to _____
Graduation Date:	Graduation Date:
Degree Earned: DDS _____ DMD _____	Specialty (MS): _____

(E) LASER USE AND CERTIFICATIONI utilize laser radiation in the performance of my practice of dentistry. Yes ☐ No ☐I certify that each laser I use in my practice of dentistry has been cleared by the United States Food and Drug Administration for use in dentistry. Yes ☐ No ☐

Attach a copy of proof of course completion of laser proficiency indicating successful completion of a recognized course pursuant to Board regulation NAC 631.033 and NAC 631.035 based on the curriculum guidelines and standards for dental laser education as adopted by the Academy of Laser Dentistry.

(F) CONTINUED CLINICAL COMPETENCYHave you been out of active practice for two or more years just prior to completing this application? Yes ☐ No ☐

If yes, attach a separate sheet with details of how you have maintained your clinical skills.

(G) HISTORY OF IMPAIRMENT

(1) Do you now, or have you ever, abused alcohol, other chemical substances, or do you have any medical/mental impairments or emotional condition(s) that would impair your ability to perform as a licensee pursuant to NRS and NAC Chapters 631? *(If yes, submit details on separate sheet)* Yes ☐ No ☐

(2) Do you now, or have you ever had, any contagious or infectious disease(s) that would impair your ability to perform as a licensee pursuant to NRS and NAC Chapters 631? *(If yes, submit details on separate sheet)* Yes ☐ No ☐

(H) DENTAL PRACTICE & EMPLOYMENT HISTORY

Have you ever been engaged in private dental practice, been employed as a dentist, been self-employed or done business under a fictitious name (D.B.A.)?

Yes ☐ No ☐

*If yes, list the following information for the past ten years including the dates you practiced dentistry: the names of all employers; partners, associates or persons sharing office space; list dates of self-employment and nature of business; list all fictitious names (D.B.A.), dates and nature of business; and the reason for leaving each practice. **If you were unemployed for any period of time please write the month and year of unemployment. (Use additional sheets if necessary)***

Current Practice Address (If any):

City:

State:

Zip Code:

Telephone:

Fax:

Email address:

(I) PREVIOUS EMPLOYMENT

1. Practice Address:

City:

State:

Zip Code:

From:

To:

(Include month/year)

Telephone:

Name of Employers, Associates, Etc...

Reason for leaving:

2. Practice Address:

City:

State:

Zip Code:

From:

To:

(Include month/year)

Telephone:

Name of Employers, Associates, Etc...

Reason for leaving:

3. Practice Address:

City:

State:

Zip Code:

From:

To:

(Include month/year)

Telephone:

Name of Employers, Associates, Etc...

Reason for leaving:

4. Practice Address:

City:

State:

Zip Code:

From:

To:

(Include month/year)

Telephone:

Name of Employers, Associates, Etc...

Reason for leaving:

5. Practice Address:

City:

State:

Zip Code:

From:

To:

(Include month/year)

Telephone:

Name of Employers, Associates, Etc...

Reason for leaving:

(J) EXAMINATION AND LICENSURE HISTORY**NATIONAL BOARD EXAMINATION****Part I** Date Taken: PASS ☐ FAIL ☐**Part II** Date Taken: PASS ☐ FAIL ☐Please list below all dental/hygiene clinical examinations in which you have participated: *(Use additional sheets if necessary)***CLINICAL EXAMS:**ADEX ☐ Date(s) of Clinical Examination: to PASS ☐ FAIL ☐WREB ☐ Date(s) of Clinical Examination: to PASS ☐ FAIL ☐**OTHER EXAMS:**

Regional/State, Territory, DC:

Date(s) of Clinical Examination: to PASS ☐ FAIL ☐

Regional/State, Territory, DC:

Date(s) of Clinical Examination: to PASS ☐ FAIL ☐Have you ever applied for a license to practice dentistry? Yes ☐ No ☐*If yes, list the following for each state, territory or the District of Columbia. Use additional sheets if necessary:*

State, Territory, DC:

Date of Application:

Result of Application (Granted, Denied, Pending):

State, Territory, DC:

Date of Application:

Result of Application (Granted, Denied, Pending):

State, Territory, DC:

Date of Application:

Result of Application (Granted, Denied, Pending):

- | | | | |
|---|---|------------------------------|-----------------------------|
| 1 | Have any proceedings been initiated against you to revoke or suspend your dental license? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 2 | At the time you filed this application, were any disciplinary proceedings pending against you, including complaints or investigations, in any other state, territory or the District of Columbia? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 3 | Have you ever been terminated or attempted to terminate or surrender a dental license in any state, territory or the District of Columbia? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 4 | Have you ever been denied a dental license in this state, another state, or a territory of the U.S. or the District of Columbia? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

If you answered 'yes' to questions J1, J2, J3 and/or J4, provide a full explanation of each answer on a separate sheet and attach to this application.

(K) MALPRACTICE

Have you ever had any claims of malpractice filed against you?

Yes ☐ No ☐

If yes, list all malpractice, negligence lawsuits and claims you have ever had against you. Include dates, names, settlements or resolutions. Please include malpractice and lawsuits that were dismissed. Provide additional pages as needed.

Do you or have you ever carried malpractice (professional liability) insurance?

Yes ☐ No ☐

List all malpractice carriers since licensed or for the past 10 years (which ever is longer). Leave no time gaps and account for periods with no insurance. Provide additional pages as needed.

Carrier:

Policy Number:

Address :

City:

State:

Zip Code:

From:

To:

(Include month/year)

Telephone:

Carrier:

Policy Number:

Address :

City:

State:

Zip Code:

From:

To:

(Include month/year)

Telephone:

Carrier:

Policy Number:

Address :

City:

State:

Zip Code:

From:

To:

(Include month/year)

Telephone:

Carrier:

Policy Number:

Address :

City:

State:

Zip Code:

From:

To:

(Include month/year)

Telephone:

Carrier:

Policy Number:

Address :

City:

State:

Zip Code:

From:

To:

(Include month/year)

Telephone:

Carrier:

Policy Number:

Address :

City:

State:

Zip Code:

From:

To:

(Include month/year)

Telephone:

(L) MORAL CHARACTER

- | | | | | | |
|---|--|-----|--------------------------|----|--------------------------|
| 1 | Have you ever been reprimanded, censored, restricted or otherwise disciplined? | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| 2 | Have any claims or complaints of malpractice, formal or informal, ever been made or filed against you, or have any proceedings been instituted against you? | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| 3 | Have you ever been arrested, convicted, charged with, entered a plea of nolo contendere or pleaded guilty to the violation of any law [misdemeanor(s) or felony(ies)]? | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |

If your answer is 'yes' to any of the foregoing questions (1-3), furnish a written statement of each occurrence giving the complete facts. For each incident, state the date, case number, the nature of the charge the disposition of the matter, and the name and address of the authority in possession of the records thereof. You must provide certified copies of any arrest or conviction and/or any plea agreements entered into for any felony(ies) or misdemeanor(s).

- | | | | | | |
|---|---|-----|--------------------------|----|--------------------------|
| 4 | Have you ever been denied participation in, or suspended from the Medicaid or Medicare benefit program? | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
|---|---|-----|--------------------------|----|--------------------------|

If your answer is 'yes' to questions 4, furnish a written statement of each occurrence giving the complete facts. For each incident, state the date, the nature of the charge the disposition of the matter, and the name and address of the authority in possession of the records thereof.

- | | | | | | | |
|---|----------------------------|-----|--------------------------|----|--------------------------|--------------------------|
| 5 | Do you hold a DEA license? | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> | If yes list DEA Number # |
|---|----------------------------|-----|--------------------------|----|--------------------------|--------------------------|

- | | | | | | |
|---|--|-----|--------------------------|----|--------------------------|
| 6 | Have you ever surrendered your DEA number or had it revoked or restricted? | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
|---|--|-----|--------------------------|----|--------------------------|

(M) STATEMENT OF CHILD SUPPORT

Pursuant to state and federal mandated requirements, I further certify that (CHECK the appropriate box):

- | | | |
|----|---|--------------------------|
| 1 | I am NOT subject to a court order for the support of one or more children. | <input type="checkbox"/> |
| 2 | I AM subject to a court order for the support of one or more children and: <i>(continue to 2a or 2b below)</i> | <input type="checkbox"/> |
| 2a | I am NOT in compliance with a plan approved by the district attorney or other public agency enforcing the order for the payment of the amount owed pursuant to the court order for the support of one or more children. | <input type="checkbox"/> |
| 2b | I AM in compliance with a plan approved by the district attorney or other public agency enforcing the order for the payment of the amount owed pursuant to the court order for the support of one or more children. | <input type="checkbox"/> |

(N) AFFIDAVIT AND PLEDGE

I hereby expressly waive all provisions of law forbidding any physician or other person who has attended or examined me or who may hereafter attend or examine me from disclosing any knowledge or information that is thereby acquired, and I hereby consent that such knowledge or information may be disclosed to the Nevada State Board of Dental Examiners.

The person named as the applicant in the foregoing application and questionnaire, being first duly sworn, deposes and says: I am the applicant for dental licensure referred to; and I have carefully read and understand the questions in the foregoing questionnaire and have answered them truthfully, fully, and completely, without mental reservation of any kind. I further understand I have a continuing obligation to inform the Board should any of my answers since filing this application change prior to the Board issuing my license. In the event I fail to update the answers which have changed since submitting this application, I understand that such failure is ground for revocation of any license issued or denial of the application.

I hereby authorize educational and other institutions, my references (past and present), business and professional associates (past and present), insurance carriers, professional societies, governmental agencies and instrumentalities (local, state, federal or foreign), and independent information gathering services to release to the Nevada State Board of Dental Examiners any information, files or records requested by the Board in connection with the processing of this application.

I hereby pledge myself to the highest standards and ethics in the Practice of Dentistry and further pledge to abide by the laws and regulations pertaining to the practice of dentistry. I understand that a violation of this pledge may be deemed sufficient cause for the revocation of a license issued by the Board.

I hereby understand and agree that the title of all licenses shall remain with the Nevada State Board of Dental Examiners and subject to surrender by Order of said Board.

I UNDERSTAND THAT ANY OMISSIONS, INACCURACIES, OR MISREPRESENTATIONS OF INFORMATION ON THIS APPLICATION ARE GROUNDS FOR REJECTION OF THIS APPLICATION AND THE REVOCATION OF A LICENSE WHICH MAY HAVE BEEN OBTAINED THROUGH THIS APPLICATION.

APPLICANT

Applicant Signature

Applicant (printed) Last Name, First, MI, Suffix (e.g., Jr.)

Date of Signature (must correspond with notary date)

Applicants Date of Birth (month/day/year)

Social Security Number

NOTARY

State of _____ County of _____

The statement on this document are subscribed and sworn before me this

_____ day of _____, 20 _____

Notary Public

My Commission Expires



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NOTARIZED AUTHORIZATION FOR RELEASE OF INFORMATION, DOCUMENTS AND RECORDS

I, _____, designate the Nevada State Board of Dental Examiners to collect, verify and maintain information, and copies of documents and records that can subsequently be provided to professional licensing boards, hospitals and other entities when I apply for licensure, staff membership, employment, or other privileges.

I request and authorize every person, institution, professional licensing board or any state in which I hold or may have held a license to practice my professional, Joint Commission on National Dental Examinations, hospital, clinic, government agency (local, state, federal or foreign), law enforcement agency, or other third parties and organizations, and their representatives to release information, records, transcripts, and other other documents, concerning my professional qualifications and competence, ethics, character, and other information pertaining to me to the Nevada State Board of Dental Examiners.

I further request and authorize that the requested information, documents and records be sent directly to:

Nevada State Board of Dental Examiners
6010 S Rainbow Blvd., Suite A-1
Las Vegas, NV 89118

I hereby release, discharge, and hold harmless the Nevada State Board of Dental Examiners, or representatives and any person furnishing information, records, or documents of any and all liability. I authorize the Nevada State Board of Dental Examiners to release information, material, documents, orders or the like relating to me or this application to any entity at my request.

By my signature below, I acknowledge that information, documents and records required to be furnished by another organization, educational institutions, individual, or any person or groups must be sent directly by such persons to Nevada State Board of Dental Examiners. I understand that Nevada State Board of Dental Examiners will not accept such information, records, or documents forwarded by me.

A photocopy or facsimile of this authorization shall be as valid as the original and shall be valid for a period of one (1) year from the date of signature.

APPLICANT

Applicant Signature

Applicant (printed) Last Name, First, MI, Suffix (e.g., Jr.)

Date of Signature (must correspond with notary date)

Applicants Date of Birth (month/day/year)

Social Security Number

NOTARY

State of _____ County of _____

The statement on this document are subscribed and sworn before me this

_____ day of _____, 20 _____

Notary Public

My Commission Expires



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REQUEST FOR OFFICIAL TRANSCRIPTS **DENTAL**

Pursuant to NAC 631.230 and NAC 631.030, applicants for dental licensure in the State of Nevada must present official certified copies of your transcripts indicating you have been awarded a degree in dental surgery/medicine from an ADA accredited dental school or college.

Please be advised, you will be required to request a certified copy of your dental school transcript be sent to the Board office at the address listed above. If you hand deliver a certified copy of your transcript, the documents must be in a sealed envelope.

Please be advised, your application will not be deemed complete until our office has received the official transcript from your dental school.



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National Practitioner Data Bank Self-Query Report

All applicants for dental or dental hygiene licensure are required to self-query the National Practitioner Data Bank. The self-query must be completed on the internet. You will need a credit card for payment of the querying fees. Instructions for accessing the self-query forms are as follows:

Go to: <https://www.npdb.hrsa.gov/ext/selfquery/SQHome.jsp>

- Click on 'Start a New Order'; read the agreements, accept the terms and click 'Submit and Continue'
- Complete steps 1-4 on-line following the instructions

Federal law requires that the self-query results be provided directly to you, the applicant/practitioner, and not a third party. You will be provided with an electronic copy (accessible online) and a paper copy (by mail) of your report. You may submit the original report you receive by mail to the Board office to the address at the top of this page, or submit the completed report by email by following these instructions:

- Open the email you received from the NPDB indicating the electronic copy of your self-query response is available and click on the link provided in that email
- Sign-in to open/view your report
- From the open report, save a copy of the report PDF to your computer
- Close the report and sign-out of the NPDB
- Return to the open email from the NPDB and click 'Forward'
- Enter the Board email address of nsbde@nsbde.nv.gov in the 'To' field, attach a copy of the PDF report to the email and click 'Send'. The original email from the NPDB is required to view the email thread and confirm authenticity.

It is important you follow these instructions for the Board staff to verify the authenticity of the report.

PLEASE NOTE: You must use a non-Apple product (i.e. – anything but an iPhone, iPad, Mac, etc.) to forward the information by email. The Board staff is unable to view all required information if submitted using an Apple product. We apologize for the inconvenience.

If you have questions pertaining to your self-query, you may contact: **Data Bank Customer Service at 800-767-6732.**



Nevada State Board of Dental Examiners

6010 S. Rainbow Blvd., Bldg. A, Ste. 1

Las Vegas, NV 89118

(702) 486-7044 • (800) DDS-EXAM • Fax (702) 486-7046

LICENSURE APPLICATION CREDIT CARD PAYMENT AUTHORIZATION FORM

Applicant Name:	Telephone #: () _____ - _____
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Dental Licensure Application	Dental Hygiene Licensure Application
Select Application Type:	Select Application Type:
<input type="checkbox"/> License by Examination – WREB (\$1200)	<input type="checkbox"/> Licensure by Examination – WREB (\$600)
<input type="checkbox"/> License by Examination – ADEX (\$1200)	<input type="checkbox"/> Licensure by Examination – ADEX (\$600)
<input type="checkbox"/> License by Endorsement (\$1200)	<input type="checkbox"/> Licensure by Endorsement (\$600)
<input type="checkbox"/> Specialty License by Credential (\$1200)	<input type="checkbox"/> Geographically Restricted (\$150)
<input type="checkbox"/> Geographically Restricted (\$600)	<input type="checkbox"/> Limited License (\$125)
<input type="checkbox"/> Limited License – Faculty / Resident (\$125)	<input type="checkbox"/> Military by Reciprocity (\$600)
<input type="checkbox"/> Limited Licensed for Supervision (\$100)	Dental Therapy Licensure Application
<input type="checkbox"/> Restricted License (\$125)	Select Application Type:
<input type="checkbox"/> Military by Reciprocity (\$1200)	<input type="checkbox"/> Licensure by Examination – WREB (\$1000)
<input type="checkbox"/> Specialty License by Application [NV licensed Dentist only] (\$125)	<input type="checkbox"/> Licensure by Examination – ADEX (\$1000)
<input type="checkbox"/> General Dental License AND Specialty License (\$1325) <i>(must select general dental license option above, also)</i>	<input type="checkbox"/> Licensure by Endorsement (\$500)
	<input type="checkbox"/> Military by Reciprocity (\$1000)
Other/Memo:	

Miscellaneous (optional):

- | |
|--|
| <input type="checkbox"/> Nevada Revised Statutes (NRS) 631 Booklet (\$3) |
| <input type="checkbox"/> Nevada Administrative Codes (NAC) 631 Booklet (\$3) |

Payment Information		
Name on Credit Card:		Method of Payment:
		<input type="checkbox"/> MasterCard <input type="checkbox"/> Visa <input type="checkbox"/> Discover
Credit Card Billing Address:		Ste. /Apt. No.:
City:	State:	Zip Code:

Credit Card Number:	CVV Code:	Expiration Date	Amount Authorized:
_____ - _____ - _____ - _____	_____	MM / 20YY	\$

Signature: _____

Date: ____ / ____ / ____