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

FACT SHEET

APPLICANTS FOR ACTIVE or RETIRED MILITARY OR SPOUSES of MILITARY PERSONNEL

(Dental and Dental Hygiene)

Thank you for your interest in applying for licensure by reciprocity for active or retired military or spouses of military personnel pursuant to the Assembly Bill 89 enacted by the Legislature effective July 1, 2015. Pursuant to state law, **ALL** applicants for licensure must meet the following eligibility requirements as set forth in NRS 631.230 (Dental) and NRS 631.290 (Dental Hygiene):

(a) Is over the age of 21 years (Dental) or Is over the age of 18 years (Dental Hygiene)
(b) Is a citizen of the United States, or is lawfully entitled to remain and work in the United States;
(c) Is a graduate of an accredited dental school or college; or an accredited dental hygiene program
(d) Is of good moral character

If you meet **all** of the requirements listed in item (a) through (d) above, you may be eligible to apply for licensure.

Jurisprudence Examination/Fingerprints

You will receive written confirmation via US Mail of the receipt of your application and application fee along with the on-line jurisprudence examination registration and the fingerprint materials.

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 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:

Dental:

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

Dental Hygiene:

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

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APPLICANT'S CHECKLIST FOR LICENSURE BY RECIPROCITY FOR ACTIVE OR RETIRED MILITARY AND MILITARY SPOUSE

(List of items to be completed by you)

_____ **Complete Application****

_____ **Application Fee****

_____ **2 x 2 color photo attached to the application****

_____ **Copy military ID, active duty orders or discharge papers****

****NOTE:** Upon receipt of the starred (**) items, the Board may issue a dental or dental hygiene license for active or retired military and military spouses prior to having all the required documents received. The license will be valid for 6 months from the approval date by the Board. Applicants will be required to have all required documents submitted no later than 6 months after the license is issued by the Board. Failure to have all the required information received no later than 6 months after approval may result in the cease and desist of clinical practice and the license being expired.

_____ **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 all required documents as set forth in NAC 631.030, your application will be reviewed by the Board's Secretary-Treasurer. 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

REV 03/2022

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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 Hygiene licensure by: ***(Please check one below)***

Licensure by ADEX Exam (NRS 631.300): $600 ☐	**Licensure by WREB Exam (NRS 631.300): $600** ☐
Limited Licensure (NRS 631.271): $125 **Resident:** ☐ **Instructor:** ☐ *Indicate Residency Program:* *Indicate Instructor Facility:*	**Restricted Geographical (NRS 631.274): $150** **Underserved County(ies):** ☐ **FQHC or Non-Profit:** ☐ *Indicate County(ies)* *Indicate FQHC Facility or Non Profit*
Military Reciprocity/Credential: $600 ☐	**License by Endorsement: $600** ☐

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. YOU WILL BE NOTIFIED WITHIN 15 BUSINESS DAYS UPON APPROVAL OF YOUR APPLICATION BY THE BOARD.***

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:*

Soc. Security #:	*Age:*	*Male* ☐ *Female* ☐	*Birthdate:*	*Birthplace (City, County, State, & Country):*

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:**

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:**

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. 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 ADDRESSES

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 SERVICE

Have 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** ☐		**Marine Corps/Marine Corps Reserve** ☐
	Navy/Navy Reserve ☐		**Air Force/ Air force Reserve** ☐
	Coast Guard/ Coast Guard Reserve ☐		**National Guard** ☐
Date of Service: From to		***Military Occupation Specialty/Specialties:***	
Branch of Service:	**Army/Army Reserve** ☐		**Marine Corps/Marine Corps Reserve** ☐
	Navy/Navy Reserve ☐		**Air Force/ Air force Reserve** ☐
	Coast Guard/ Coast Guard Reserve ☐		**National Guard** ☐

(D) EDUCATION & CERTIFICATIONS

DENTAL HYGIENE EDUCATION:

Dental Hygiene School:

City:	***State:***
Years Attended: (month/year) **to**	**Graduation Date:**

Degree Earned: **Associates** ☐ **Bachelors** ☐

(E) LASER USE AND CERTIFICATION

I utilize laser radiation in the performance of my practice of dental hygiene. **Yes** ☐ **No** ☐

I certify that each laser I use in my practice of dental hygiene has been cleared by the United States Food and Drug Administration for use in dental hygiene. **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 COMPETENCY

Have 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 HYGIENE PRACTICE & EMPLOYMENT HISTORY

Have you ever been employed as a dental hygienist? **Yes** ☐ **No** ☐

If yes, list the following information for the past ten years including the dates you practiced dental hygiene: the names of all employers 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. Address:	*City:*	*State:*	*Zip Code:*

From: *To:* *(Include month/year)*	**Telephone:**

Name of Employers:	*Reason for leaving:*

2. Practice Address:	*City:*	*State:*	*Zip Code:*

From: *To:* (Include month/year)	**Telephone:**

Name of Employers:	*Reason for leaving:*

3. Practice Address:	*City:*	*State:*	*Zip Code:*

From: *To:* (Include month/year)	**Telephone:**

Name of Employers:	*Reason for leaving:*

4. Practice Address:	*City:*	*State:*	*Zip Code:*

From: *To:* (Include month/year)	**Telephone:**

Name of Employers:	*Reason for leaving:*

5. Practice Address:	*City:*	*State:*	*Zip Code:*

From: *To:* (Include month/year)	**Telephone:**

Name of Employers:	*Reason for leaving:*

(J) EXAMINATION AND LICENSURE HISTORY

NATIONAL BOARD EXAMINATION

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** ☐

OTHERS 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** ☐

RegionaL/State, Territory, DC:

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

Have you ever applied for a license to practice dental hygiene? **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 hygiene license?**	**Yes** ☐	**No** ☐
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** ☐	**No** ☐
3	**Have you ever been terminated or attempted to terminate or surrender a dental hygiene license in any state, territory or the District of Columbia?**	**Yes** ☐	**No** ☐
4	**Have you ever been denied a dental hygiene license in this state, another state, or a territory of the U.S. or the District of Columbia?**	**Yes** ☐	**No** ☐

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, neglience lawsuits and claims you have ever had against you. Include dates, names, settlements or resolutions. Please include malpractice and lawsuits that were dismissed. Provide additonal 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** ☐	**No** ☐
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** ☐	**No** ☐
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** ☐	**No** ☐

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** ☐	**No** ☐

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.

(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.**	☐
2	**I AM subject to a court order for the support of one or more children and: (*continue to 2a or 2b below*)**	☐
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.**	☐
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.**	☐

(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 hygiene 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 Dental Hygiene and further pledge to abide by the laws and regulations pertaining to the practice of dental hygiene. 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 notory date)

_____
Applicants Date of Birth (month/day/year)

_____
Social Security Number

NOTORY

State of _____ **County of** _____

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

_____ **day of** _____ **,20** _____

_____
Notory Public

_____
My Commission Expires

Nevada State Board of Dental Examiners

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NOTARIZED AUTHORIZATION FOR RELEASE OF INFORMATION, DOCUMENTS AND RECORDS

I, _____, designate the Nevada State Baord 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
2651 N Green Valley Parkway Suite 104
Henderson, NV 89014

I hereby release, discharge, and hold harmless the Nevada State Board of Dental Examiners, or representatives and any person furnshing 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 Nevad 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 orginal 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 notory date)

_____
Applicants Date of Birth (month/day/year)

_____
Social Security Number

NOTORY

State of _____ **County of** _____

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

_____ **day of** _____ **,20** _____

_____
Notory Public

_____
My Commission Expires

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CERTIFICATION OF PROFICIENCY IN ADMINISTRATION OF

LOCAL ANESTHESIA AND NITROUS OXIDE OXYGEN ANALGESIA

I HERBY CERTIFY that _____ (*name of applicant)* has successfully completed a course, including administration, in one or both of the following (*please check and complete appropriate line*)

_____ (a) Local Anesthesia on _____ (*date)*

_____ (b) Nitrous Oxide Oxygen Analgesia on _____ (*date)*

_____
ORIGINAL SIGNATURE OF DEAN / PROGRAM DIRECTOR
(No stamped signatures)

OFFICIAL SEAL OF ACCREDITED
DENTAL HYGIENE SCHOOL OR UNIVERSITY

_____
Printed name of Dean / Program Director and date

_____
Name of Educational Entity

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REQUEST FOR OFFICIAL TRANSCRIPTS DENTAL HYGIENE

Pursuant to NAC 631.290 and NAC 631.030, applicants for dental hygiene licensure in the State of Nevada must present official certified copies of your transcripts indicating you have been awarded a degree in dental hygiene from an ADA accredited dental hygiene school or college.

Please be advised, you will be required to request a certified copy of your dental hygiene 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 hygiene program.

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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.**

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LICENSURE APPLICATION CREDIT CARD PAYMENT AUTHORIZATION FORM

Applicant Name:	**Telephone #: ( ) _____ - _____**

Dental Licensure Application	**Dental Hygiene Licensure Application**
Select Application Type:	**Select Application Type:**
☐ License by Examination – WREB ($1200)	☐ Licensure by Examination – WREB ($600)
☐ License by Examination – ADEX ($1200)	☐ Licensure by Examination – ADEX ($600)
☐ License by Endorsement ($1200)	☐ Licensure by Endorsement ($600)
☐ Specialty License by Credential ($1200)	☐ Geographically Restricted ($150)
☐ Geographically Restricted ($600)	☐ Limited License ($125)
☐ Limited License – Faculty / Resident ($125)	☐ Military by Reciprocity ($600)
☐ Limited Licensed for Supervision ($100)	**Dental Therapy Licensure Application**
☐ Restricted License ($125)	**Select Application Type:**
☐ Military by Reciprocity ($1200)	☐ Licensure by Examination – WREB ($1000)
☐ Specialty License by Application [NV licensed Dentist only] ($125)	☐ Licensure by Examination – ADEX ($1000)
☐ General Dental License AND Specialty License ($1325) *(must select general dental license option above, also)*	☐ Licensure by Endorsement ($500)
	☐ Military by Reciprocity ($1000)
Other/Memo:	

Miscellaneous (optional):
☐ Nevada Revised Statutes (NRS) 631 Booklet ($3)
☐ Nevada Administrative Codes (NAC) 631 Booklet ($3)

Payment Information		
Name on Credit Card:	**Method of Payment:** ☐ MasterCard | ☐ Visa | ☐ 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:** ___/___/___