



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

APPLICATION TO REACTIVATE AN INACTIVE / RETIRED LICENSE

Name _____ Current Phone _____ Email _____

Complete Mailing Address _____

I, _____, wish to reactivate my inactive Dental / Dental Hygiene (circle one) license number _____, which was placed on inactive/retired status on _____. I certify (choose one below):

_____ I have maintained an active license and practice (active license and working) outside the state of Nevada during the period my Nevada license has been **inactive**;

Requirements for reactivation are:

1. Payment of the reactivation fee of **\$300.00** in addition to the pro-rated current active license fees. You will need to contact the Board office for confirmation of the correct fees to pay;
2. Provide a list of employment during the time the Nevada license was inactive; including the office name, address, telephone number and dates employed;
3. Submit proof of current CPR certification (online certification is NOT acceptable);
4. Submit proof of completion of continuing education credits as follows (courses must be completed within the previous 12 months):
 - a. For Dentists reactivating, 20 credit hours are required (of those 20, a minimum of 10 MUST be live-instruction and a minimum of 2 must be in infection control);
 - b. For Hygienists reactivating, 15 credit hours are required (of those 15, a minimum of 7.5 MUST be live-instruction and a minimum of 2 must be in infection control);
5. A current self-query report from the National Practitioners Data Bank dated (no more than 90 days old; copies not accepted);
6. Provide certification letter (no more than 90 days old) from each state in which you currently hold a license (regardless of the status) to practice dentistry or dental hygiene, that the license is in good standing and that no proceedings which may affect that standing are pending;

_____ I have not maintained an active license and practice (no active license and not working) for one or more years outside the state of Nevada during the period my Nevada license has been **inactive or retired**;

Requirements for reactivation are:

1. **For licenses on inactive/retired status for less than 2 years:**
 - a. Complete items (1) through (5) above.
2. **For licenses on inactive/retired status for 2 years or more:**
 - a. Complete items (1) through (5) above;
 - b. Pass such additional examinations for licensure as the Board may prescribe.

I attest that I am in compliance with the reporting requirements regarding service of claims or complaints of malpractice, felony or misdemeanor convictions, the suspension, revocation or probation of my license by another licensing jurisdiction or child support order (if applicable) pursuant to NAC 631.155 and NRS 631.225. If not previously reported, **FULL DISCLOSURE OF EACH SUCH CASE MUST BE ENCLOSED WITH THIS REACTIVATION APPLICATION.**

I authorize and empower the Nevada State Board of Dental Examiners or its agent to contact any person, firm, service, agency, or the like to obtain information deemed necessary or desirable by the Board to verify any information contained in my application to reactivate my inactive/retired license based upon this affidavit. I acknowledge I have a continuing responsibility to update all information contained in this application until such time as the Board takes 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.

STATE OF _____

COUNTY OF _____

SIGNATURE OF LICENSEE _____ DATE _____

SUBSCRIBED TO AND SWORN BEFORE ME, this _____ day of _____, 20_____

SEAL

NOTARY PUBLIC IN AND FOR SAID COUNTY AND STATE



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

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 board_licensing@dental.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

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: () - -		_____	
NV License Number:	<input type="checkbox"/> Dental <input type="checkbox"/> Dental Hygiene	Suite No.: _____	City: _____
		State: _____	Zip Code: _____

Dental Licensure Application Fees	
<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) <i>(If applying for a general dental license & specialty license concurrently, application fee will be \$1325)</i>	

Dental Hygiene Licensure Application Fees	
<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)	

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

Dental Anesthesia Permit Fees	
Permit Application: \$ _____ (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)	

License Renewal Fees	
<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)	

Renewal: \$ _____ Permit No.: _____
(choose one): <input type="checkbox"/> General Anesthesia <input type="checkbox"/> Moderate Sedation
<input type="checkbox"/> Site Permit

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

Permit Re-Inspection: \$ _____
(choose one): <input type="checkbox"/> Administration Permit Re-inspection (\$500)
<input type="checkbox"/> Site Permit Re-inspection (\$350)

Request for Duplicate Certificate Fees	
<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="checkbox"/> GA Admin. Permit No.: _____	
<input type="checkbox"/> Mod. Sedation Admin. Permit No.: _____	
<input type="checkbox"/> Peds Mod. Sed Admin. Permit No.: _____	
<input type="checkbox"/> Site Permit No.: _____	

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

Other: _____

Miscellaneous Fees	
<input type="checkbox"/> NRS Booklet (\$3) x _____	
<input type="checkbox"/> Returned Check Fee (\$25)	
<input type="checkbox"/> Civil Penalty \$ _____	
<input type="checkbox"/> Continuing Education Provider Fee: (1 st Hour = \$150 / each additional hour = \$50)	
Total Hours: _____ Total Fee: \$ _____	

<input type="checkbox"/> NAC Booklet (\$3) x _____
<input type="checkbox"/> Change of Address Fine (\$50)
<input type="checkbox"/> Investigation Costs \$ _____

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