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

2x2 passport photo must be attached
(No older than 6 months)
Do not staple photo to application

LICENSURE APPLICATION

An application is considered complete only upon the Board's receipt of all required documentation. Applications expire one (1) year from the date of receipt. Before submitting this application, please review the Licensure Application Guide to confirm that you have met the requirements for licensure in the State of Nevada. Incomplete applications—including those that are illegible or not notarized—will be returned. Applicants are required to notify the Board of **ANY** changes related to the information provided in this application, including but not limited to complaints, arrests, address changes, and name changes.

A. LICENSE APPLICATION TYPE

1. *License Type Applying For

Dentistry Licenses:	○ General Dentist	○ Specialty Dentist	○ Restricted Geographical
	○ Restricted License	○ Limited License Resident	○ Limited License Instructor
	○ Limited License Supervising CE		
Dental Hygiene Licenses:	○ Registered Dental Hygienist	○ Restricted Geographical	○ Limited License Instructor
Dental Therapist:	○ Dental Therapist	○ Restricted Geographical	○ Limited License Instructor
Expanded Function Dental Assistant (EFDA):	License type currently not available. Anticipated Launch Q3 2026.		

B. CONTACT INFORMATION

1.	*First Name:	*Middle Name:	*Last Name:
2.	*Email Address:	*Cell Phone Number:	Alt Phone Number:
3.	Residence Street Address:		Apt/Ste:
4.	City:	State:	Zip Code:

☐ Mailing Address is the same as Residence Address (*please note that if your application is approved, your mailing address will automatically become your public record address unless a Change of Address form is filed.*)

5.	*Mailing Address:		*Apt/Ste:
6.	*City:	*State:	*Zip Code:

If currently practicing, provide your practice address (**If you're not currently practicing**, skip to Section C)

7.	Practice Name:		
8.	Residence Street Address:		Apt/Ste:
9.	City:	State:	City:

If you are currently practicing at more than one dental practice/facilities, you must list them all on an additional sheet of paper and provide their physical address. Be sure to reference the section letter, B(7-9), on the attached sheet.

C. PERSONAL INFORMATION

1. *Social Security Number:	*Date of Birth:	*Gender: ○ Male ○ Female

2. *If you have used any former names throughout your life (first, middle, last and/or maiden), please list each name used along with the year it changed, and attach legal documentation supporting each name change, such as a court order, marriage certificate, or the relevant page of a divorce decree showing the name change.

   If you have never changed your name, write "N/A"

Former Names (First, Middle, Last, and/or Maiden)	Year of Change

If you have more former names than lines provided above, you must list them all on an additional sheet of paper. Be sure to reference the section letter, C(2), on the attached sheet and attach legal documentation for each name change.

3. *United States Work Authorization Status: ○ US Citizen ○ Legal Resident ○ Naturalized Resident

   *Attach a copy of your work authorization documentation such as a birth certificate, passport, permanent resident card, employment work authorization card, naturalization certificate, etc. to the application.

4. If Legal/Naturalized Resident, provide Registration Number:

5. Registration Issuance Date: Registration Expiration Date:

D. LICENSE APPLICATION PATHWAY

1. *Licensure Pathway

○ Examination (ADEX | WREB) ○ Endorsement
○ Specialty Credentials (active dentists only) ○ Military Credential (active/retired miliary or military spouses)
○ Limited or Restricted License ○ Restricted Geographical

2. Specialty by Credential ONLY (*Active Dentists Only*)

Indicate Certification Status: ○ Board Eligible ○ Diplomate

Select the Specialty that you will practice (If you have more than one (1) specialty, reference the Licensing Guide for details):

☐ Orthodontia ☐ Endodontia ☐ Periodontia ☐ Prosthodontia
☐ Pediatric Dentistry ☐ Public Health Dentist ☐ O & M Pathology ☐ O & M Radiology
☐ O & M Surgery ☐ Dental Anesthesiology ☐ Oral Medicine ☐ Orofacial Pain

3. Limited Licenses ONLY (*Instructor, Resident, or Supervisor*)

Provide the name of the residency program, instructor, facility, or CE provider:

4. Restricted License ONLY

Provide the name of the facility approved by the division of Department of Health and Human Services exclusively for serving low-income patients:

D. LICENSE APPLICATION PATHWAY CONTINUED

5. Restricted Geographical ONLY

Select One: ○ Rural area ○ Federally qualified health center or Non-profit clinic (Washoe or Clark County)

Provide the rural counties/federally qualified health centers/non-profits serving:

_____

If there are more counties/federally qualified health centers/non-profits than lines provided above, you must list others on an additional sheet of paper. Be sure to reference the section letter, D(5), on the attached sheet.

6. Historically Underserved Community (HUC)

*Have you accepted an offer of employment from an employer that meets the definition of Historically Underserved Community Employer as defined in the Licensure Application Guide? ○ Yes ○ No

If yes, you must provide a copy of your employment letter with your application. You may not utilize the Historically Underserved Community Employer licensure pathway without a valid employment letter.

Provide the intended employment start date for the Historically Underserved Community Employer:

E. EDUCATION

1.	*Educational Program Type (Check one):	☐ Dental Hygienist Program ☐ Dental Therapy Program	☐ Doctoral Program ☐ EFDA Program
2.	*Highest Degree Earned (Check one):	☐ Certificate ☐ Bachelors ☐ Doctoral (DDS)	☐ Associates ☐ Masters ☐ Doctoral (DMD)
3.	*Educational Institution Name:		
4.	*Institution City:	*Institution State:	*Did you Graduate? ○ Yes ○ No
5.	If Yes, Graduation Date:	If No, Expected Graduation Date:	
6.	*Did you attend a postdoctoral program in a specialty or obtain advanced education in dentistry?		○ Yes ○ No
7.	**If Yes**, Postdoctoral Educational Institution Name:		
8.	Postdoctoral Program: ☐ GPR ☐ AEGD ☐ Specialty Program List Specialty:		
9.	Institution City:	Institution State:	Did you Graduate? ○ Yes ○ No
10.	**If Yes**, Graduation Date:	Did you receive a Specialty Certificate/Diploma?	○ Yes ○ No

F. EXAMINATION

National Board Examination

1. *National Board Exam Overall Results: ○ Pass ○ Fail

(Optional) DENTPIN # _____

*Integrated Exam Date: *Part 1 Date: *Part 2 Date:

Clinical Examination

2.	Clinical Exam Taken: ○ ADEX ○ WREB	Clinical Exam Overall Results:	○ Pass ○ Fail
3.	Dates Taken: to		

F. EXAMINATION CONTINUED

Other Clinical Examination(s)

4. If you have taken other examinations, list the names of other examinations below and provide a certificate or exam results showing the exam was successfully passed.

	Examination	Results
1		○ Pass ○ Fail
2		○ Pass ○ Fail

If you have successfully passed more examinations than lines provided above, you may list others on an additional sheet of paper. Be sure to reference the section letter, F(4), on the attached sheet.

G. LICENSURE QUESTIONNAIRE

1. *Have you held a professional dental license in the state of Nevada? ○ Yes ○ No

   If yes, provide your NV dental license number:

2. *Are you applying for licensure to join a residency program or another dental affiliated program? ○ Yes ○ No

   If yes, state the name of the residency program/dental affiliated program and estimated start date:

   Program Name: Date:

3. *Are you licensed as a dental professional in another state/jurisdiction? ○ Yes ○ No

   If yes, list all State(s)/Jurisdiction(s) that you hold/held a dental-related professional license and the status:

State/Jurisdiction	License #	Status

If you are licensed in more states/jurisdictions than lines provided above, you must list all others on an additional sheet of paper. Be sure to reference the section letter, G(3), on the attached sheet and attach to the application.

4. *Have you ever been denied licensure as a dental professional in another state/jurisdiction? ○ Yes ○ No

   If yes, you must provide a written explanation on a separate sheet of paper. Be sure to list the section letter, G(4), on the additional sheet, and attach the supporting documentation for all dental licensure denials to the application.

5. *Have you ever been the subject of a professional license complaint or proceeding in another state/jurisdiction, whether or not they resulted in any liability finding or penalty, including any claims or complaints of malpractice filed against you, whether in a court of law or with an administrative body (such as a dental or medical board)? ○ Yes ○ No

   If yes, you must provide a written explanation on a separate sheet of paper. Be sure to list the section letter, G(5), on the additional sheet, and attach the documentation for all complaints or proceedings initiated against you to the application.

G. LICENSURE QUESTIONNAIRE CONTINUED

6. *Have you or your professional license(s) been subject to any level of disciplinary action (reprimand - public or private, censored, restricted, suspended, etc.) by any state or jurisdictional government body? ○ Yes ○ No

   If yes, you must provide a written explanation on a separate sheet of paper. Be sure to list the section letter, G(6) on the additional sheet, and attach the documentation for all disciplinary actions taken against you or your license(s) to the application.

7. *Have you ever surrendered a professional dental license in another state/jurisdiction? ○ Yes ○ No

   If yes, you must provide a written explanation on a separate sheet of paper. Be sure to list the section letter, G(7), on the additional sheet, and attach the documentation regarding the license surrender to the application. Provide license number and the jurisdiction where it occurred.

8. *Have you ever used or do you actively use alcohol, illegal drugs, or prescription medications in a manner that impaired or impairs your ability to practice safely, including any participation in rehabilitation programs related to substance abuse? ○ Yes ○ No

   If yes, you must provide a written explanation on a separate sheet of paper; your explanation must include relevant information such as the substance abuse type, the rehabilitation program name, and the date range from and to which you experienced this condition (indicate "to present" if a current or ongoing condition). Be sure to list the section letter, G(8), on the additional sheet. You must also include with your application a signed and dated Health Insurance Portability and Accountability Act (HIPAA) and the Nevada Consumer Health Data Privacy Law release form. See the License Application Guide for details on completing the release form.

9. *Do you have any health or medical condition that, if untreated, permanently impairs or could impair your ability to practice dentistry or dental hygiene safely? This includes any physical or mental conditions that may limit your clinical capacity or pose risks to patient safety. ○ Yes ○ No

   If yes, you must provide a written explanation on a separate sheet of paper; your explanation must include the relevant condition, the treating provider, and the date range from and to which you experienced this condition (indicate "to present" if a current or chronic condition). Be sure to list the section letter, G(9), on the additional sheet. You must also include with your application a signed and dated Health Insurance Portability and Accountability Act (HIPAA) and the Nevada Consumer Health Data Privacy Law release form. See the License Application Guide for details on completing the release form.

H. EMPLOYMENT INFORMATION

1. *Have you worked as a licensed dentist, dental therapist, dental hygienist, or EFDA? ○ Yes ○ No

   If yes, how many years have you been practicing as a licensed dentist, dental therapist, dental hygienist, or EFDA?

2. List all dental practices/facilities where you have worked in the past ten (10) years, the start and end date of your employment at each practice/facility, and the city/state of each practice/facility. If you were not employed in the dental field during this period, indicate this by stating "Unemployed" under "Practice/Facility" and note the applicable dates.

	Practice/Facility	City	State	Start Date (MM/YYYY)	End Date (MM/YYYY)
1					
2					
3					
4					
5					

If there are more dental practices/facilities/periods of unemployment than lines provided above, you must list others on an additional sheet of paper. Be sure to reference the section letter, H(2), on the attached sheet and attach to the application.

H. EMPLOYMENT INFORMATION CONTINUED

3.	*Have you ever been denied participation in or suspended from the Medicaid or Medicare benefits program? **If yes**, you must provide a written explanation on a separate sheet of paper. Be sure to list the section letter, H(3), on the additional sheet, and attach the documentation showing the denial, revocation, or suspension of your Medicaid or Medicare coverage and billing privileges.	○ Yes ○ No
4.	*Have you been out of active dental practice for two or more years prior to completing this application for licensure? **If yes**, you must provide a written explanation on a separate sheet of paper. Be sure to list the section letter, H(4), on the additional sheet, and attach any corroborating documentation you see fit.	○ Yes ○ No

I. MILITARY INFORMATION

1.	*Have you or your spouse ever served in the military? (**If no**, skip to Section J) **If yes**, you must attach a copy of supporting documentation (applicant's military ID, military orders, or discharge paperwork) to the application.			○ Yes ○ No
2.	**If yes**, in which branch(es) of the military have you served? (check all that apply)	☐ Air Force ☐ Marines ☐ Space Force	☐ Army ☐ Navy ☐ Reserves	☐ Coast Guards ☐ National Guard
3.	**If yes**, Start Date of Military Service:	**If yes**, End Date of Military Service: (if still active, state "Present")		
4.	What is or was your military profession or your military spouse's profession?			

J. COURT/LEGAL HISTORY

1.	*Have you ever been arrested, convicted, or charged with the violation of any law [misdemeanor(s) or felony(ies)], irrespective of whether you entered a plea of nolo contendere, pleaded guilty, or the case or charges were ultimately dismissed? Include juvenile cases or offenses, even if ultimately expunged. **If yes**, you must provide a written explanation of all criminal legal proceedings on a separate sheet of paper. Be sure to list the section letter, J(1), on the additional sheet(s). The written explanation should describe the incident underlying the charges and any resulting legal proceedings, including dates, nature of the charge(s), and dispositions of each charge. Attach records of any arrests, convictions, nolo contendere pleas, guilty pleas, or stayed adjudications/submittals on the record to the application.	○ Yes ○ No
2.	*Are you subject to a court order for child support? (**If no**, skip to Question 4)	○ Yes ○ No
3.	**If yes**, are you in compliance with a plan approved by the district attorney or other public agency enforcing the child support order and/or any child support arrears payments?	○ Yes ○ No
4.	*Have you ever filed for bankruptcy? **If yes**, you must provide a written explanation of all bankruptcy proceedings on a separate sheet of paper. Be sure to list the section letter, J(4), on the additional sheet(s). Attach records of any bankruptcy plans, discharges, or orders.	○ Yes ○ No

J. COURT/LEGAL HISTORY CONTINUED

5. *Have you ever been the subject of a creditor lawsuit, default judgement, mortgage foreclosure, lien, garnishment of wages, debt settlement/payment agreement, or any other legal proceeding where you were adjudged financially insolvent or in default of a credit obligation? ○ Yes ○ No

   If yes, you must provide a written explanation of all finance-related legal proceedings, judgements, or payment agreements on a separate sheet of paper. Be sure to list the section letter, J(5), on the additional sheet(s). Attach records of any finance-related legal proceedings, judgements, or payment agreements.

K. CERTIFICATIONS

Drug Enforcement Agency (DEA) Certification

1. *Do you hold a DEA registration number? (**If no**, skip to Question 4) ○ Yes ○ No

2. **If yes**, what is the DEA registration number?

3. **If yes**, provide DEA registration issuance date:

   If yes, provide DEA registration expiration date:

4. Have you ever had your DEA license revoked or suspended? ○ Yes ○ No

   If yes, you must provide a written explanation on a separate sheet of paper. Be sure to list the section letter, J(3), on the additional sheet, and attach documentation regarding the revocation or suspension of the DEA license to the application, including the date the DEA license was revoked or suspended.

Cardiopulmonary Resuscitation (CPR) Certification

5. *Have you completed CPR certification? (**If no**, skip to Question 6) ○ Yes ○ No

   If yes, you must attach a copy of the CPR Certification to the application.

Laser Certification

6. *Are you planning to use laser radiation in practice? (**If no**, skip to Question 8 or 9 accordingly) ○ Yes ○ No

7. **If yes**, was the course certified by Academy of Laser Dentistry (ALD) or based on the Curriculum Guidelines and Standards for Dental Laser Education? ○ Yes ○ No

   If yes, you must attach a copy of your current laser certification to the application. The certification should state that the course was based on *Curriculum Guidelines and Standards for Dental Laser Education and is a minimum of 6 CEs*.

DENTAL HYGIENISTS ONLY – Local Anesthesia/Nitrous Oxide Permits

8. **For dental hygienists only**, are you planning to utilize local anesthesia and/or nitrous oxide under dentist supervision in practice? (**If no**, skip to Question 12) ○ Yes ○ No

   If yes, the NSBDE must receive a completed Certificate of Proficiency (CoP) form from your educational institution or certified course syllabus of post-graduate program. Review the Licensure Application Guide for detailed instructions on how to properly submit the CoP form.

DENTISTS ONLY – Neuromodulator and Dermal/Soft Tissue Filler Certification/Permit

9. Are you planning to administer certain neuromodulators related to Clostridium botulinum and dermal or soft tissue fillers in practice upon licensure? (**If no**, skip to Question 12) ○ Yes ○ No

10. Do you have certifications from a Board approved course for use of neuromodulators related to Clostridium Botulinum and dermal /soft fillers? *(Board approved courses may be found on the NSBDE website)* ○ Yes ○ No

    If yes, you must attach a copy of your Board approved certifications related to Clostridium Botulinum and dermal /soft filler to the application and show you have taken *a minimum of 24 CE credits regarding neuromodulators and dermal/soft fillers*.

K. CERTIFICATIONS CONTINUED

DENTISTS ONLY – Neuromodulator and Dermal/Soft Tissue Filler Certification/Permit CONTINUED

11.	**If yes**, provide the dermal or soft tissue filler certification/permit issuance date:	**If yes**, provide the dermal or soft tissue filler certification/permit expiration date:

EFDAS ONLY – Expanded Functions Auxiliary Certification

12. Do you hold an expanded functions dental auxiliary certification? (**If no**, skip to Question 14) ○ Yes ○ No

13.	**If yes**, provide the expanded functions Dental auxiliary certification issuance date:	**If yes**, provide the expanded functions Dental auxiliary certification expiration date:

Other Certifications/Permits/Credentials

14. If applicable, list all other dental professional certifications/permits/credentials currently active, the expiration date of each, and attach them to the application.

Certifications/Permits/Credentials	Exp Date (MM/DD/YYYY)

If there are more certifications/permits/credentials than lines provided above, you may list others on a separate sheet of paper. Be sure to list the section letter, K(14), on the additional sheet, and attach documentation for other certifications/permits/credentials.

L. APPLICANT ATTESTATIONS *(Initial All to Designate Agreement)*		
1.	*I affirm that, if I am currently certified to use neuromodulators and/or dermal or soft tissue fillers, or become certified to use these in the future, I will ensure that each neuromodulator and/or each dermal or soft tissue filler that I inject is approved for use in dentistry by the United States Food and Drug Administration.	Initial
2.	*I affirm that, if I am currently certified to use lasers, or become certified to use lasers in the future, any laser I use in the practice of dentistry is approved for use in dentistry by the United States Food and Drug Administration.	Initial
3.	*I affirm that I have reported any felony or misdemeanor convictions. These may include offenses involving fraud, substance use or possession, physical harm, or crimes of moral turpitude, consistent with NAC 631.030(1)(h) and (i) and NAC 631.155(4). I am aware that even cases expunged or dismissed can show up on a criminal background investigation, and thus I should disclose out of an abundance of caution to avoid an inference of dishonesty. I understand that failure to report all incidents may result in disciplinary action and/or denial or revocation of my license.	Initial
4.	*I affirm that I have disclosed any instances where I was under the influence of alcohol, illegal drugs, or prescription medications in a way that impaired my ability to practice safely, and any participation in rehabilitation programs related to substance abuse. This is germane to qualifications under NAC 631.030(k).	Initial
5.	*I affirm that I have reported any significant changes in my health or medical condition that could impair my ability to practice dentistry or dental hygiene safely. This includes physical or mental conditions that may limit my clinical capacity or pose risks to patient safety.	Initial
6.	*I affirm that, if I answered affirmatively to Question F(9), I hereby give the Board my express consent and permission to obtain any and all of my medical records and give my physicians currently in possession of my medical records express consent and permission to provide any and all of my medical records to the Board, in conjunction with the completed and signed HIPAA and Nevada Consumer Health Data Privacy Law release form included with this application. I also affirm that, if the treatment of my condition(s) affords me the capability to safely practice dentistry without posing a patient safety risk, I will adhere to my provider's treatment plan and will voluntarily disengage from patient contact if I fail to or cannot be treated for my condition until such time as my treatment resumes and my ability to practice dentistry safely returns.	Initial
7.	*I affirm that I have disclosed all professional liability or malpractice claims or settlements that I have been involved in. This is germane to qualifications under NAC 631.030(j), (n), and)(p). I understand the importance of maintaining standards of care and accountability in my practice and will seek to avoid committing unprofessional conduct as outlined in NRS 631.346 *et. seq*.	Initial
8.	*I affirm that I have reported any disciplinary actions taken against me by other states or licensing jurisdictions. This is germane to qualifications under NAC 631.030 (n) and)(p). I acknowledge the requirement to maintain transparency once licensed, and I will self-report certain events to the Board outlined in NAC 631.155.	Initial
9.	*I hereby authorize all educational institutions, references, current and former employers, business and professional associates, insurance providers, professional organizations, government agencies (local, state, federal, or international), and independent background check services to release any information, records, or files requested by the Nevada State Board of Dental Examiners for the purpose of reviewing and processing my application.	Initial
10.	*I affirm that I have reported any incidents of financial insolvency, bankruptcy, significant financial judgments, or payment agreements that could relate to my professional practice or patient trust funds, inclusive of child support requirements or delinquencies outlined in NRS 631.225.	Initial
11.	*I affirm my commitment to adhere to all regulations and standards established by the Nevada State Board of Dental Examiners, the Nevada Revised Statutes, and the Nevada Administrative Code. To that end, I acknowledge self-reporting duties when my conduct could or did jeopardize public health or safety, involved dishonesty, or caused substantial harm to patients or the public. As a result, I agree to promptly report any unusual incidents or adverse outcomes, including the death of a patient, the infliction of physical or mental injury, or the hospitalization of a patient during or as a result of a dental procedure, consistent with NAC 631.155. I understand that fulfilling these responsibilities is crucial to maintaining the integrity of the profession and safeguarding patient trust.	Initial

L. APPLICANT ATTESTATIONS *(Initial All to Designate Agreement)* CONTINUED		
12.	*I affirm my commitment to uphold the highest standards of ethics and professionalism in the practice of dentistry. I further pledge to comply with all laws and regulations governing the profession. I understand that any violation of this pledge may be considered valid grounds for the Nevada State Board of Dental Examiners to revoke a license issued to me.	Initial
13.	*I understand and agree that all licenses are issued by and remain under the authority of the Nevada State Board of Dental Examiners, and must be returned to the Board upon request—whether due to voluntary surrender, non-renewal, or disciplinary action.	Initial
14.	*I hereby authorize the Nevada State Board of Dental Examiners to collect, verify, and maintain information, documents, and records about me. I understand that these materials may later be provided to professional licensing boards, hospitals, or other entities when I apply for licensure, staff membership, employment, or related privileges.	Initial
15.	*I hereby release and hold harmless the Nevada State Board of Dental Examiners, its staff, representatives, and any person or entity providing information and/or documentation, from any and all liability that may arise from the release or use of such information and from the investigation or declination of this application.	Initial
16.	*I hereby authorize any individual, institution, professional licensing board (in any state where I currently hold or have previously held a license), the Joint Commission on National Dental Examinations, hospital, clinic, government agency (local, state, federal, or foreign), law enforcement agency, or any other organization — and their representatives — to release to the Nevada State Board of Dental Examiners any records, transcripts, evaluations, or other documents concerning my professional qualifications, competence, ethics, and character.	Initial
17.	*I also authorize the Nevada State Board of Dental Examiners to release information, documents, records, orders, or related materials concerning me or my application to any organization or entity at my written request.	Initial

APPLICANT

Owner Signature

Owner Name (printed) Last Name, First Name, MI, Suffix

Date of Signature (must correspond with notary date)

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

M. LICENSE ACTIVATION

1. *I affirm I have read NRS 631.330 and am aware of the licensure period for my respective license type as detailed below:

LICENSE RENEWAL PERIODS	
ODD YEARS	General Dentist, Specialty Dentist, Restricted Geographical Dentist
EVEN YEARS	Dental Hygienists, Restricted Geographical Hygienist, Dental Therapists, EFDAs
ANNUAL	Restricted License, Limited License, Limited License Instructor, Limited License Supervising CE

By signing the below, I acknowledge my understanding of this section.

Signature _____ Date _____

2. ANNUAL LICENSEE APPLICANTS ONLY (If Biannual Licensee Applicant, skip to Question 3)

I acknowledge that the annual license period runs from the date my application is approved for a full year (365 days), and NOT for a calendar year.

By signing the below, I acknowledge my understanding and agreement of this section.

Signature _____ Date _____

3. BIANNUAL LICENSEE APPLICANTS ONLY

i. I acknowledge that the biannual license periods run from July 1 to June 30, and NOT for a calendar year. Thus, if my initial license application is approved and activated prior to 6/30 during a renewal year for my license type, I acknowledge I will be responsible for meeting all renewal documentation and certification requirements for the license cycle starting 7/1. This includes paying renewal fees and taking and certifying continuing education credits.

By signing the below, I acknowledge my understanding and agreement of this section.

Signature _____ Date _____

ii. If you are submitting this form as your initial application before June 30th of given year, but you do not wish to meet both initial and renewal licensure requirements within the same calendar year as described above, you may request to defer the activation of your license until a date after July 1 of the same year the application is received. Only requests for applications pending approval within 90 days of the renewal date will be considered.

Do you wish to submit a request to defer activation? ○ Yes ○ No

If yes, you must provide a written explanation stating the reason for your request and your desired activation date on a separate sheet of paper. Only requests for applications received within 90 days of the renewal date will be considered; the requested activation date must fall between July 1 and December 31 of the same year. Be sure to list the section letter, M(3), on the additional sheet(s).

N. APPLICATION ACKNOWLEDGEMENT

I acknowledge and agree that, once payment is made, I will not be entitled to a refund of any amount, even if I change my mind about being licensed by the State of Nevada and seek to withdraw my application or surrender my license prior to activation. I understand that the money paid with the application compensates the Board for staff time associated with processing the application and completing character and fitness investigations, which occur whether or not I ultimately benefit from the license originally sought.

By signing below, I acknowledge my understanding of the requirements laid out within the application and the provisions in NRS 631 and NAC 631. I understand I am responsible to maintain compliance with all applicable regulations and standards of the Nevada State Board of Dental Examiners.

Signature _____ Date _____

O. LICENSE APPLICATION FEES

DENTIST				
☐ General License by: Exam (WREB or ADEX)	☐ Endorsement	☐ Military Reciprocity		**$1,200.00**
☐ Specialty License by Cred.				**$1,325.00**
☐ Limited License – Faculty/Resident	☐ Restricted License			**$125.00**
☐ Geographically Restricted	**$600.00**	☐ Limited Licensed for Supervision		**$100.00**
DENTAL HYGIENIST				
☐ RDH License by: Exam (WREB or ADEX)	☐ Endorsement	☐ Military Reciprocity		**$600.00**
☐ Geographically Restricted	**$150.00**	☐ Limited License		**$125.00**
DENTAL THERAPIST				
☐ Dental Therapist	**$1,000.00**	☐ Limited License		**$300.00**
☐ Restricted Geographical License	**$300.00**			
EFDA				
License is not available at this time				
MISCELLANEOUS FEES				
☐ NRS Booklet - OUT OF STOCK	**$3.00 per book**	☐ NAC Booklet - OUT OF STOCK		**$3.00 per book**

PAYMENT METHOD

Payment Method: ☐ Check/Money Order (attach with application) ☐ Credit/Debit Cards (credit cards will incur a 3% surcharge)				**Total Amount Authorized**
Name on Card:	Card Number - - -			
Card Billing Address:	Exp Date:	CVV:		
Street:	City:	State:	Zip:	$

You may mail or drop off your completed application with payment to

Nevada State Board of Dental Examiners
Attention: Licensing Department
2651 N Green Valley Pkwy Ste 104
Henderson NV 89014