IDAHO STATE BOARD OF DENTISTRY

♦PO BOX 83720 BOISE, ID 83720-0021 ♦PHONE: (208) 334-2369 ♦FAX: (208) 334-3247
♦WEBSITE: www.isbd.idaho.gov ♦EMAIL: sbdinfo@isbd.idaho.gov

DENTAL HYGIENIST APPLICATION
LICENSURE BY EXAMINATION

In order to be eligible for licensure by examination, you must have taken and passed a Board approved examination within the five (5) years immediately preceding the date of application.

CHECKLIST

	Completed Application with Non-Refundable Application Fee Mail to: ISBD, PO Box 83720, Boise, ID 83720-0021 Express Mail: 350 N 9TH Street, Suite M100, Boise, ID 83702
	Copy of Current CPR Certification
	Original or Notarized Copy of National Board Scores
	Original or Notarized Copy of Clinical Examination Results* The Idaho Board of Dentistry Accepts the Following Examinations: Western Regional Examining Board (WREB), Central Regional Dental Testing Service (CRDTS), and ADEX.
	Original or Notarized Copy of WREB* Local Anesthesia Exam
	Official Transcripts Transcripts must have degree posted and must be sent in a sealed envelope.
	License Verification (Included with Application Materials) – If Applicable License Verification Forms must be received directly from every state an applicant has held a license.
	Jurisprudence Exam This will be mailed to the applicant upon receipt of the application.

**** Applicants may login and view/print their exam results from WREB or ADEX. These results do not need to be notarized, and may be printed and mailed with the application.***

Important Information

- The Idaho State Board of Dentistry conducts a thorough evaluation of all application materials. Process times for applications may range from several weeks to several months.
- Application requirements are set to comply with the Idaho Dental Practice Act. No exceptions will be made and requirements will not be waived under any circumstance.
- Application files will remain active for six (6) months from the date the application is received.
- Upon receipt of the application, information will be sent to you on how to check your application status online.
- If you relocate during the time that your application is being processed, you must immediately notify the Board of your new address.

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Application for Licensure by Examination-Dental Hygiene

☐ Dental Hygienist by Exam--Application fee $150
(The Idaho Board of Dentistry currently accepts: cash, check, money order, or cashier's check)

Personal Information

Full Name (First, Middle, Last, Suffix)		
Maiden Name or Other Names Used	SSN	
Mailing Address		
City	State	Zip
Email Address	Phone #:	
Date of Birth	Active Duty Military Yes No Branch_____	Gender Male Female
Place of Birth City State Country		

Education

Dental Hygiene School Name & Location	Dates Attended	Degree Received

Examinations

List every license-related examination you have taken **regardless of the result.**

Examination	Date Taken	Result

State Licensure

List every state in which you are or have been licensed as a Dental Hygienist and/or states in which an application is pending. **If not applicable, answer N/A**.

State	Type of License	License #	Date Issued	Status

Work/Professional Experience

Provide a chronological list of all work and professional experience beginning from the date of your graduation from Dental Hygiene school to the present date. **If not applicable, answer N/A**.

Name and Address of Employer	Dates Worked: From MM/YY To MM/YY	Hours Worked Per Week

APPLICANT NAME: _____

PERSONAL DATA QUESTIONS	YES	NO
1. Were you ever expelled, requested to withdraw, reprimanded or placed on probation while attending any dental/dental hygiene school/program?		
2. Have you ever been refused or denied the privilege of taking any examination required for professional licensure?		
3. Have you ever been dismissed from any professional licensure examination due to improper behavior or unethical conduct?		
NOTE: IF YOU ANSWERED "YES" TO QUESTIONS (1), (2), OR (3), YOU MUST ATTACH A SIGNED WRITTEN STATEMENT PROVIDING A COMPLETE EXPLANATION OF THE EVENT OR CIRCUMSTANCES.		
4. Have you ever been denied a license to practice dentistry/dental hygiene or any other profession or occupation?		
5. Have you ever voluntarily surrendered a license to practice dentistry/dental hygiene and/or have you ever agreed to voluntarily restrict or limit your practice of dentistry/dental hygiene?		
6. If you answered "YES" to QUESTION (5), was disciplinary action pending against you, were you under investigation by a licensing agency at that time or, did you surrender or agree to restrict or limit your practice of dentistry/dental hygiene in lieu of disciplinary action being taken against you? ☐ N/A		
7. Have you ever been the subject of any proceeding by a licensing authority which either sought or resulted in censure, reprimand, probation, suspension, surrender, revocation, fine or other discipline/penalty in connection with any dental/dental hygiene or other professional license you held?		
8. Are charges or an investigation currently pending in connection with your dental/dental hygiene license in any other state?		
9. Have your clinical privileges or procedures ever been restricted by any hospital, outpatient clinic, or surgery center?		
10. Have you ever had a registration issued by a controlled substance authority revoked, suspended, surrendered, limited or restricted?		
11. Have you ever voluntarily surrendered a registration issued by a controlled substance authority?		
12. Are any professional liability or malpractice claims or complaints currently in process/pending against you?		
13. Have any settlement agreements been entered into or have any judgments been entered against you resulting from your practice of dentistry/dental hygiene?		
14. Have any judgments or settlements been paid on your behalf as a result of a professional liability or malpractice case(s)?		
15. Have you ever been denied participation in, or suspended from the Medicaid or Medicare benefit program?		
NOTE: FOR EACH "YES" ANSWER TO ANY QUESTIONS 4 – 15, YOU MUST ATTACH A SIGNED WRITTEN EXPLANATION AND PROVIDE COPIES OF ALL JUDGMENTS, DECISIONS, AND/OR AGREEMENTS.		
16. Are you currently or have you ever been licensed in any other state in any health care profession aside from dentistry/dental hygiene?		
17. Have you ever been discharged other than honorable from the armed service or from a city, county, state, or federal position?		
18. Do you currently have a child-support obligation?		
19. If yes, are you in arrears? ☐ N/A		
20. If yes, does the arrearage match or exceed the total amount payable for the past six months? ☐N/A		
NOTE: IF YOU ANSWERED "YES" TO QUESTIONS (16), (17), (18), (19), OR (20), YOU MUST ATTACH A SIGNED WRITTEN STATEMENT PROVIDING A COMPLETE EXPLANATION AND ATTACH ANY SUPPORTING DOCUMENTATION.		

APPLICANT NAME: _____

PERSONAL DATA QUESTIONS CONTINUED	YES	NO
21. Have you had or do you currently have a medical condition that in any way impairs or limits your ability to currently practice dentistry/dental hygiene safely and competently?		
22. Have you ever engaged in the improper use of drugs or other chemical substances?		
23. Have you used or do you currently use alcohol, drugs, or other chemical substances in a manner that would in any way impair or limit your ability to safely and competently practice dentistry/dental hygiene?		

NOTE:

"Ability to practice dentistry/dental hygiene safely and competently" means ALL of the following:
1. The cognitive capacity to make reasoned clinical judgments, and to learn and keep abreast of clinical developments;
2. The ability to communicate clinical judgments and information to patients and other health care providers; and
3. The capability to perform clinical tasks such as dental/dental hygiene examinations and dental/dental hygiene procedures.

"Medical condition" means any physiological or psychological condition, impairment, or disorder, including drug addiction and alcoholism.

"Drugs or chemical substances" mean alcohol, controlled substances, prescription drugs, illegal drugs, over-the-counter medications, nitrous oxide, petroleum products, adhesive products and other chemical substances taken for mood alteration.

"Improper use of drugs or other chemical substances" means ANY of the following:
1. The use of any controlled substance and/or prescription drug in an addictive manner and/or for any purpose and to any extent other than as directed by a licensed health care practitioner;
2. The use of any over-the-counter medication in an addictive manner and/or in a manner prohibited by law;
3. The use of alcohol in an addictive manner and/or to the extent that the use of alcohol impairs a person's ability to safely and competently practice as a dentist;
4. The manufacture, possession, distribution or use of any drug, medication or chemical substance in a manner prohibited by law.

24. If you answered "YES" to any questions 21 - 23, have you participated in any program or received treatment or are you currently participating in any program or receiving treatment that reduces or eliminates the limitations or impairments caused by either your medical condition or improper use of alcohol, drugs, or other chemical substances? ☐ N/A		
25. If you answered "YES" to any questions 21-23, does your field of practice, the setting, or the manner in which you practice dentistry/dental hygiene, reduce or eliminate the limitations or impairments caused by either your medical condition or improper use of alcohol, drugs, or other chemical substances? ☐ N/A		

NOTE: IF YOU ANSWERED "YES" TO ANY QUESTIONS 21 - 25, YOU MUST ATTACH A SIGNED WRITTENT STATEMENT ATTESTING THAT YOU ARE PHYSICALLY AND MENTALLY ABLE TO PERFORM THE FUNCTIONS OF THE LICENSE YOU SEEK AND THAT THERE ARE NO MEDICAL CONSIDERATIONS IN YOUR HEALTH HISTORY THAT MAY POSE A THREAT TO THE PATIENTS YOU TREAT AND ATTACH ANY DOCUMENTATION INCLUDING COPIES OF EVALUATIONS AND RECOMMENDATIONS FOR TREATMENT IF ANY WERE ISSUED.

APPLICANT NAME: _____

PERSONAL DATA QUESTIONS CONTINUED	YES	NO
26. Have you ever been arrested, charged, cited, indicted, found guilty of, or entered a plea of guilty or no contest to a felony or misdemeanor crime or offense, including actions that resulted in a deferred or expunged judgment?		
27. Have you ever received a withheld judgment or suspended sentence for any felony or misdemeanor in a criminal proceeding?		
28. Do you have any felony or misdemeanor criminal charges currently pending against you in any state or country?		
29. Are you currently charged with or have you been convicted of a criminal act that requires registration under the Sex Offender Registration Act?		
NOTE: IF YOU ANSWERED "YES" TO ANY QUESTION 26 – 29, YOU MUST SEND DOCUMENTATION SUCH AS CERTIFIED COPIES OF ALL COURT DOCUMENTS RELATED TO YOUR CRIMINAL HISTORY. DOCUMENTATION MAY INCLUDE COPY OF CRIMINAL CHARGES, REPORTED OFFENSE, POLICE REPORT, JUDGMENT AND DISPOSITION, FINAL DISPOSITION, AND ANY ORDERS OR ANY ACTIONS PENDING. BE SURE TO INCLUDE THE JURISDICTION THAT IS INVESTIGATING AND/OR PROSECUTING THE CHARGES. THIS INCLUDES ANY CITY, COUNTY, STATE, FEDERAL, OR TRIBAL JURISDICTION.		

AFFIDAVIT OF APPLICANT

STATE OF _____ COUNTY OF_____

I, _____ , hereby declare under penalty of perjury that I am the person described and identified in this application and that the attached photograph is a true likeness of myself. I also declare that I am the lawful holder of the requisite diploma, which was procured in the regular course of instruction and examination without fraud or misrepresentation.

I further state that I have read the statutes and rules pertaining to the practice of dentistry/dental hygiene as prescribed in Chapter 9, Title 54, Idaho Code and IDAPA 19.01.01 of the Board of Dentistry's Administrative Rules. If a license to practice dentistry/dental hygiene is issued to me, I understand that if I violate any laws or rules, my license may be disciplined as provided by law.

I declare, under penalty of perjury, that my answers and all statements made by me on this application and accompanying attachments are true and correct. Should I furnish any false information, or cause any material omission, I hereby agree that such act shall constitute cause for denial, suspension, or revocation of my license. I also declare under penalty of perjury that if I did not personally complete the foregoing application, or any portion hereof, that I have fully read and confirmed each question and accompanying answer, and take full responsibility for all answers contained in this application.

I hereby agree to abide by the laws and rules pertaining to the practice of dentistry/dental hygiene in the state of Idaho.

Signature of Applicant _____

Subscribed and Sworn to before me this _____ day of _____, _____

Signature of Notary Public _____

Notary Public for _____ My commission expires: _____

NOTARY SEAL

ATTACH CURRENT PHOTOGRAPH HERE

AUTHORIZATION FOR RELEASE OF PERSONAL INFORMATION

I _____ do hereby authorize a full disclosure of all records concerning myself to any duly authorized employee, officer or agent of the Idaho State Board of Dentistry, whether the said records are of a public, private, or confidential nature.

I hereby authorize all hospitals, schools, educational institutions, or organizations, personal physicians, employers (past and present), business and professional associates (past and present) and all governmental agencies and instrumentalities (local, state, federal or foreign) to release to this licensing board any information, files or records requested by this board in connection with the processing of this application. I further authorize this board to release to the organizations; individuals and groups listed above any information that is material to my application.

I understand that any information obtained by a personal history background investigation, which is developed directly or indirectly, in whole or in part, upon this authorization for release will be considered in determining my suitability for a license to practice dentistry/dental hygiene in the State of Idaho. I also certify that any person(s) or entity which may furnish such information concerning me shall not be held accountable for giving this information; and I do hereby release said person(s) from any and all liability which may be incurred as a result of furnishing such information. I further release the Idaho State Board of Dentistry from any and all liability, which may be incurred as a result of requesting or obtaining such information.

A photocopy of this release form will be valid as an original thereof, even though the said photocopy does not contain an original writing of my signature.

This authorization for release is non-expiring and shall continue in force and effect indefinitely.

I have read and fully understand the contents of the "Authorization for Release of Personal Information" and do knowingly and voluntarily execute same.

_____ _____

Signature of Applicant Date

CERTIFICATION OF LICENSURE

As part of the license application process, the Idaho State Board of Dentistry requires that this form be completed by every board that has ever issued any license to the applicant, even if the license is not current. The completed form must be mailed directly from the state licensing board to the **Idaho State Board of Dentistry.** Any processing fees are the applicant's responsibility. The applicant's signature authorizes release of information, favorable or otherwise, directly to the Board.

Print Name _____ **License #**_____

Signature _____ **Date** _____

****

This portion of the form should be completed by the state licensing board.

IT IS HEREBY CERTIFIED THAT _____
(Name of Applicant)

WAS GRANTED LICENSE NUMBER_____ **DATE ISSUED**_____

TO PRACTICE_____ **IN THE STATE OF**_____

DATE LICENSE EXPIRES_____ **LICENSE STATUS**_____

BASIS FOR LICENSURE:

- ☐ **Endorsement/Credentials**
- ☐ **State Board Prepared Written and/or Clinical Exam**
- ☐ **Regional Clinical Exam, Name of Testing Agency** _____

☐ **YES** ☐ **NO** **Disciplinary action ever been initiated, pending, or taken? (If yes, please provide contact information to obtain further information regarding disciplinary action.)**

STATE LICENSING BOARD OFFICIAL:

Print Name _____ **Title** _____

Signature _____ **Date**_____

Phone #_____ **Fax #**_____

Return completed form to:

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State or Board Seal