



IDAHO STATE BOARD OF DENTISTRY

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EXTENDED ACCESS DENTAL HYGIENE LICENSE ENDORSEMENT APPLICATION

Please complete the attached application and mail to: ISBD, PO Box 83720, Boise, ID 83720-0021. For express mail, send to: 350 N 9TH Street, Suite M100, Boise, ID 83702.

If you are applying for a restorative endorsement, in addition to the application please submit a copy of your WREB Restorative Exam results or current restorative permit from another state.

To determine which endorsement best fits your needs; please see the attached Extended Access Dental Hygiene License Endorsement reference guide.

Important Information

- Idaho Code §54-903 (9): "Extended access oral health care program" means and includes: (a) Dental and dental hygiene treatment and services provided as part of a program conducted by or through a school district, county, state or federal agency, hospital, long-term care facility, public health district, dental or dental hygiene school, tribal clinic, or federally qualified health center; or (b) Oral health care programs approved by the board and conducted by or through a nonprofit public or private entity, organized in accordance with section 501(c)(3) or 501(c)(4) of the federal Internal Revenue Code, that provide free dental or dental hygiene services to persons who, due to age, infirmity, indigence, disability or other similar reason, may be unable to receive regular dental and dental hygiene treatment
- Idaho Board of Dentistry Administrative Rule 19.01.01.029.03: an Extended Access Dental Hygiene License Endorsement must be renewed in conjunction with the dental hygienist's license on a biennial basis on or before April 1ST of each odd numbered calendar year. There is no biennial renewal fee in connection with this endorsement.

Extended Access Dental Hygiene License Endorsement Quick Reference Guide

	Extended Access	Extended Access with Restorative	Extended Access Restorative Only
Requirements	<ul style="list-style-type: none"> Licensed as a dental hygienist during the two (2) year period prior to the date of application (unless employed in an extended access oral health care program in this state). Practiced a minimum of one thousand (1000) clinical hours within the previous two (2) years (unless employed in an extended access oral health care program in this state). Have not been disciplined by the Board or another licensing authority 	<ul style="list-style-type: none"> Licensed as a dental hygienist during the two (2) year period prior to the date of application (unless employed in an extended access oral health care program in this state). Practiced a minimum of one thousand (1000) clinical hours within the previous two (2) years (unless employed in an extended access oral health care program in this state). Successful completion of the WREB Restorative or equivalent exam. Have not been disciplined by the Board or another licensing authority 	<ul style="list-style-type: none"> Successful completion of the WREB Restorative or equivalent exam. Have not been disciplined by the Board or another licensing authority
Services Performed	All specified duties of a licensed dental hygienist under general supervision.	All specified duties of a licensed dental hygienist under general supervision. Placement of a restoration into a tooth prepared by a dentist and the carving, contouring and adjustment of the contacts and occlusion of the restoration.	The placement of a restoration into a tooth prepared by a dentist and the carving, contouring and adjustment of the contacts and occlusion of the restoration.
Supervision Level	General	For Extended Access Services – General For Restorative Services – Direct	Direct
Required for Renewal	Four (4) verifiable credits in any of these specified practice areas: medical emergencies, local anesthesia, oral pathology, care and treatment of geriatric, medically compromised or disabled patients, and treatment of children.	Four (4) verifiable credits in any of these specified practice areas: medical emergencies, local anesthesia, oral pathology, care and treatment of geriatric, medically compromised or disabled patients, and treatment of children.	Not Required

Verification of Clinical Practice

For the two (2) year period immediately preceding the date of application, list the following information. **If not applicable, answer N/A.**

<u>Name and Address of Office Where Clinical Practice Occurred</u>	<u>From MM/YY</u> <u>To MM/YY</u>	<u>Hours of Clinical Practice Per Week</u>

Are you currently employed as a dental hygienist in an extended access oral health care program in Idaho?

- YES NO

If yes, please provide the name, address, and telephone number of the extended access oral health care program and the name of your supervisor.

Have you ever been disciplined or had your license restricted by any state licensing authority?

- YES NO

If yes, provide an explanation setting forth the type of discipline or restriction imposed, the date upon which the disciplinary action or restriction was imposed and the grounds for the disciplinary action or restriction on your license.

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.

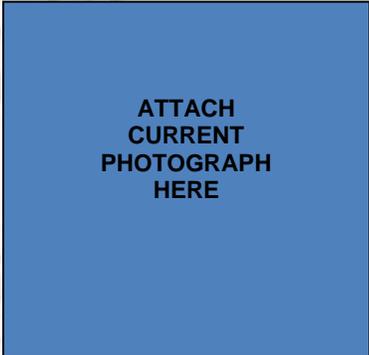
Signature of Applicant _____

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

Signature of Notary Public _____

Notary Public for _____ My commission expires: _____

NOTARY SEAL



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