Print Form

**STATE OF TENNESSEE**
**DEPARTMENT OF HEALTH**
**DIVISION OF HEALTH LICENSURE AND REGULATION**
**OFFICE OF HEALTH RELATED BOARDS**
**665 MAINSTREAM DRIVE**
**NASHVILLE, TENNESSEE 37243**

**TENNESSEE BOARD OF DENTISTRY**
**(615) 532-5073 or 1-800-778-4123**
**http://tn.gov/health/topic/Dentistry-board**

# APPLICATION AND INSTRUCTIONS FOR LICENSURE AS A DENTAL HYGIENIST

Application, practice, and renewal as dental hygienists is governed by T.C.A.§63-5-101, et. seq. and Rules 0460-01-.01, et. seq**.**

1. **All application fees are non-refundable**.

2. All documents and fees required to be submitted by you or which must be requested from the appropriate institutions in this application process, must be mailed directly to:

**Tennessee Board of Dentistry**
**665 Mainstream Drive**
**Nashville, Tennessee 37243**

3. Allow fourteen (14) working days for information mailed to our office to be received and placed in your file. Federal Express or special courier services will not reduce the processing time. Additionally, if Federal Express or special courier services are used you will be responsible for charges incurred.

4. If the application is not complete upon receipt by the Board's administrative office, a deficiency letter will be sent to you by certified mail. The supporting documentation requested in the letter must be received in the Board's administrative office sixty (60) days from the date of the initial deficiency letter. **Files not completed within sixty (60) days will be closed.**

5. It is recommended that you do **not** set a specific date to begin practice as a dental hygienist in Tennessee until you are granted a license by the Tennessee Board of Dentistry. Please allow a minimum of 4 to 6 weeks for processing.

6. **IT'S THE LAW!** If you change your mailing address, you must notify the Board's Administrative Office, in **writing,** within thirty (30) days. Failure to abide by this law could affect your license, since failure to receive the renewal application does not relieve you of the responsibility for timely renewal.

7. ANSWER ALL QUESTIONS ON THE APPLICATION. DO NOT LEAVE ANY AREA BLANK. RESPOND "NOT APPLICABLE" or (N/A) TO ALL QUESTIONS THAT DO NOT APPLY!

**IMPORTANT: You must have a license issued by the Tennessee Board of Dentistry before you may lawfully practice as a Dental Hygienist in Tennessee.**

**You must write your social security number on the application for it to be complete. State law requires social security numbers on this application. TCA § 36-5-1301(a), as authorized by 42 U.S.C. § 405(c)(2)(C)(i). The number will be used to verify your identity and for any other purpose allowed by state or federal law.**

There are three (3) avenues for licensure as a dental hygienist in Tennessee. Below are definitions of each avenue. Please carefully read and determine the process that is applicable to you.

1. **Examination** - This requirement is applicable to any dental hygienist who has successfully completed one of the following examinations: Southern Regional Testing Agency (SRTA), Commission on Dental Competency Assessments (CDCA) [formally Northeast Regional Board (NERB)], Central Regional Dental Testing Service (CRDTS), Western Regional Examining Board (WREB) or Council of Interstate Testing Agencies (CITA. Please refer to Rule 0460-03-.01 and the Board's policy on the ADEX examination for more information. Council of Interstate Testing Agency (CITA) examination is accepted if it was the ADEX examination that was administered.

2. **Criteria Approval** - This requirement allows a dental hygienist who is licensed in another state and has actively practiced for three (3) of the preceding five (5) years to be considered for licensure without taking a regional examination. Any accepted regional examination must never have been failed to qualify by criteria approval. Please refer to Rule 0460-03-.02 for more information.

3. **Limited Educational License** - This process is applicable to a dental hygienist licensed in another state and who will be teaching in a dental hygiene educational institute. This type of license limits the practice location to programs offered by the educational institution. Upon termination of faculty appointment the license is void. This type of licensure requires a special type of application. Please request this application from our office. Please refer to Rule 0460-03-.03 for more information.

## CHECKLIST – USE TO COMPLETE YOUR APPLICATION.

**NOTE: All submissions must be executed and dated less than one (1) year before receipt, or they will be rejected by the Board.**

| | | **Done** |
|---|---|---|
| 1. | Tape to the first page of the application a passport-size photograph of yourself (taken within the last twelve (12) months); then sign the front of the photograph. | _____ |
| 2. | Complete pages 1 through 6 of the application. Sign page 6 of the application and mail all six (6) pages to the Board's Office. | _____ |
| 3. | Paperclip a check or money order in the amount of One Hundred Twenty-Five Dollars (**$125**), if applying by examination, or One Hundred Seventy-Five Dollars (**$175**), if applying by criteria, made payable to the Board of Dentistry to the front of the application. | _____ |
| 4. | Request an official transcript from the institution from which you completed your ADA accredited dental hygiene program. The transcript must be mailed directly to the Board of Dentistry. | _____ |
| 5. | If you **are** or **have ever been** licensed, certified, registered, or permitted by any state to practice as a dental hygienist (or any other health care professional), you must request a verification from each and every state. The verification must be mailed directly to the Board's Office from the other state(s). | _____ |
| 6. | Request to have your National Board scores forwarded directly to the Board of Dentistry if you did not request Tennessee receive the scores upon graduation. There is a fee for duplicate scores. The scores can be requested online at http://www.ada.org/prof/ed/testing/nbdhe/index.asp or by contacting the Joint Commission on National Dental Examinations · 211 East Chicago Avenue, Suite 600 · Chicago, IL 60611-2637 · 800-232-1694. | _____ |
| 7. | Submit two (2) original letters of recommendation on letterhead from dental professionals who can attest to your character as a dental hygienist. These letters must identify the individuals as dental professionals and **must be originals**. ***If applying by criteria, the letters of recommendation must be from a Dentist.*** | _____ |
| 8. | If applying by criteria, proof of practice as a dental hygienist in another state for three (3) of the preceding five (5) years must be submitted from previous employers [supervising dentist(s) or office manager(s)]. The letters must indicate the dates of employment and the average number of hours worked per week. | _____ |

9. Copy the front and back of your current CPR card on a full-sized sheet of paper. The CPR certification must be a BLS Healthcare Provider course, or CPR/AED for the Professional Rescuer, or an equivalent course, which provides training for healthcare professionals in CPR and the use of an AED. The course must be conducted in person and include a skills examination on a manikin with a certified instructor. _____

10. Attach proof of U.S. or Canadian citizenship or evidence of being legally entitled to live in the U.S. (e.g. copy of birth certificate, voter's registration card, U.S. passport, naturalization papers, or current visa status.) _____

11. Please read the instructions on page 4 of the application carefully. You must answer "Yes","No",or "N/A" to **every** question. **If any of your answers to the "competency questions" on pages 4 and 5 of the application were in the affirmative, please submit a separate document to explain the situation.** In addition to your explanation, the final documents or orders from the issuing states, courts and/or agencies must be submitted. _____

12. If you took the Southern Regional Testing Agency (SRTA) examination within the last five (5) years, your scores were automatically sent to the Board of Dentistry and do not need to be requested from SRTA. If you took any other accepted regional examination, you will need to request that the testing agency send your scores directly to the Board's Administrative office. _____

**NOTE:** Anyone applying by examination who took any accepted regional examination **more than five (5) years ago** may be required to appear before the Board for an interview at the next regularly scheduled meeting of the Board (normally January, May and September).

To have your scores mailed, please contact SRTA at (757)318-9082 or www.srta.org , WREB at (602)944-3315 or www.wreb.org, NERB (now the Commission on Dental Competency Assessments-CDCA) at (301) 563-3307 or http://www.cdcaexams.org/, CRDTS at www.crdts.org/ or (785) 273-0380 or CITA at (919) 460-7750 or www.citaexam.com/.

13. **A criminal background check is required.** For instructions to obtain a criminal background check, go to http://tn.gov/health/article/CBC-instructions. _____

14. Applicants who have failed the National Board or any regional examination three (3) times must successfully complete a remedial course of post-graduate studies as a school accredited by the ADA before consideration for licensure by the Board. The program director of the post-graduate program must provide written documentation of the content of such course and certify successful completion. _____

15. All applicants must complete, sign and have notarized the Declaration of Citizenship form and submit the documents required by the Declaration of Citizenship form. The Declaration is available online at http://tn.gov/assets/entities/health/attachments/PH-4183.pdf. _____

**IT'S THE LAW!** If you change your mailing address, you must notify the Board's Administrative Office, in **writing,** within thirty (30) days. Failure to abide by this law could effect your license, since failure to receive the renewal application does not relieve you of the responsibility for timely renewal.

**Additional certifications that you can add to your license:**

- Administration of Local Anesthesia – see Rule 0460-03-.12 – requires an additional application
- Administration and Monitoring of Nitrous Oxide Certification - see Rule 0460-03-.06
- Prosthetic Function Certification - see Rule 0460-03-.10
- Restorative Function Certification - see Rule 0460-03-.10

Proof of completion of the required education must be submitted. These procedures cannot be performed until the certification is added to your license. Unless the certification course was offered as part of the ADA accredited dental hygiene program you attended, you must be licensed as a dental hygienist before attending the above certification courses. Please see the rule sections mentioned above for additional requirements and restrictions.

ATTACH A CURRENT FULL-FACE PHOTOGRAPH (SIGNED BY APPLICANT ON THE FRONT OF THE PHOTOGRAPH)

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
DIVISION OF HEALTH LICENSURE AND REGULATION
OFFICE OF HEALTH RELATED BOARDS
665 MAINSTREAM DRIVE
NASHVILLE, TENNESSEE 37243

**FOR OFFICIAL USE ONLY**

**BY EXAM**

| | |
|---|---|
| 1202-001 | $115 |
| 1202-006 | $ 10 |
| | $125 |

**BY CRITERIA**

| | |
|---|---|
| 1202-001 | $115 |
| 1202-001 | $ 50 |
| 1202-006 | $ 10 |
| | $175 |

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# APPLICATION FOR LICENSURE AS A DENTAL HYGIENIST

Please complete each question and return the application, supporting documents, and the appropriate application fee to the above address.

## PERSONAL INFORMATION

Name: _____
Last First Middle Maiden (if not used as your middle name)

Social Security Number: _____ U.S. Citizen: Yes ___ No____
All applicants must complete the Declaration of Citizenship form

Date of Birth: _____ Entitled to Live and Work in the U.S. Yes ___ No___

Mailing Address: _____

_____ Zip _____

Practice Address*: _____

_____

_____ Zip _____

E-mail address: _____

Do you wish to receive notifications, including renewal notification, from Department of Health via email? Please note, by opting in, all correspondence from the Department of Health will be delivered to the email address on file for you. You will no longer receive physical mail from our office. ___Yes ___ No

Race: _____ Phone: Home: _____

Gender: Female _____ Male _____ Office: _____

Are you a member of the U.S. armed forces who has, within the preceding 180 days, retired from the armed forces, received any discharge other than a dishonorable discharge from the armed forces, or been released from active duty to a reserve component of the armed forces? (If yes, please provide proof of status.) Yes ____ No _____

Are you the spouse of a member of the armed forces who has been transferred by the military to Tennessee or who has, within the preceding 180 days, retired from the armed forces, received a discharge other than a dishonorable discharge from the armed forces or been released from active duty to a reserve component? (If yes, please provide proof of same.) Yes ____ No _____

Have you ever been known by any other names besides what is listed above? Yes ____ No _____

If yes, please state in full every other name by which you have been known, the reason therefore, and inclusive dates so known: _____

_____

***If you have no practice address, notify the Board of your practice address within 30 days of obtaining a practice address. If you have multiple practice address, please attach an additional page listing all practice addresses.**

## EDUCATIONAL AND EMPLOYMENT INFORMATION

Please provide the following information for all educational institutions you have attended beyond high school. Use the back of this page if you need additional space. Request an official transcript be submitted directly from the ADA accredited educational institution where you completed your dental hygiene program.

| From: | To: | Educational Institution | City, State | Degree Earned | Year Graduated |
|---|---|---|---|---|---|
| Mo./Yr. | Mo./Yr. | | | | |
| Mo./Yr. | Mo./Yr. | | | | |
| Mo./Yr. | Mo./Yr. | | | | |
| Mo./Yr. | Mo./Yr. | | | | |

Please complete your entire employment history starting with the most current position first. Use the back of this page if you need additional space.

| Company/ Employer: | Address: (City, and State) | Position: | Duties: | Dates From: Mo./Yr. | Dates To: Mo./Yr. |
|---|---|---|---|---|---|
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## CERTIFICATION INFORMATION

| | YES | NO |
|---|---|---|
| Are you or have you ever been licensed in this profession in another state? | ____ | ____ |
| Are you or have you ever been licensed in any other profession in Tennessee or another state? | ____ | ____ |

List below **ALL STATES, COUNTRIES, OR PROVINCES IN WHICH YOU HAVE EVER BEEN OR ARE CURRENTLY LICENSED, PERMITTED, OR CERTIFIED**. Additional pages may be added if necessary. Request that verification of licensure be submitted directly to the Board's Office from each state.

| STATE | PROFESSION | LICENSE NUMBER | CURRENT STATUS |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

| | | YES | NO |
|---|---|---|---|
| 1. | Have you taken the National Boards exam? | ____ | ____ |
| 2. | Have you ever previously applied for a dentist, dental hygiene, or dental assisting license in Tennessee? | ____ | ____ |
| 3. | Have you ever taken the Southern Regional Testing Agency (S.R.T.A.) exam? | ____ | ____ |
| 4. | Have you ever taken the Western Regional Examining Board (WREB) exam? | ____ | ____ |
| 5. | Have you ever taken the North East Regional Board (NERB) or Commission on Dental Competency Assessments (CDCA) exam? | ____ | ____ |
| 6. | Have you ever taken the Central Regional Dental Testing Service (CRDTS) exam? | ____ | ____ |
| 7. | Have you ever taken the Council of Interstate Testing Agency (CITA) exam? | ____ | ____ |

Please circle below which clinical exam you took and indicate the exam site and the date when you successfully completed the examination. If you took more than one clinical examination, please list the information on each.

Clinical Exam(s) Taken: SRTA WREB NERB/CDCA CRDTS Other: _____

Exam Site(s): _____

Date Exam(s) Taken: _____

## COMPETENCY INFORMATION

PLEASE ANSWER THE FOLLOWING QUESTIONS. If you answer "yes" to any of the questions in this part, you must supplement your affirmative response with a thorough explanation on a separate page. IN SUPPORT OF YOUR EXPLANATION, THE FINAL DOCUMENTS OR ORDERS FROM THE ISSUING STATES, COURTS, AND/OR AGENCIES MUST BE SUBMITTED ALONG WITH THIS APPLICATION. Additional information may be requested and/or required before a licensure decision may be made. For the purposes of these questions, the following phrases or words have the following meanings:

1. "**Ability to practice your profession**" is to be construed to include all of the following:

a. The cognitive capacity to make appropriate clinical diagnoses, exercise reasoned medical judgments, to learn, and keep abreast of medical developments;

b. The ability to communicate those judgments and medical information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and

c. The physical capability to perform professional tasks and procedures required of your profession, with or without the use of aids or devices, such as corrective lenses or hearing aids.

2. "**Medical Condition**" includes physiological, mental or psychological conditions including, but not limited to: orthopedic, visual, speech and/or hearing impairments, emotional or mental illness, specific learning disabilities, drug addiction, and alcoholism.

3."**Minor Traffic Offense**" generally means moving and non-moving violations punishable by fines only and does not include offenses such as driving under the influence or while intoxicated or reckless driving.

4. "**Chemical substances**" is to be construed to include alcohol, drugs, or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

5. "**Currently**" does not mean on the day of or even in the weeks or months preceding the completion of this application. Rather it means recently enough so that the use of drugs or alcohol may have an ongoing impact on one's functioning as a licensee or within the past two (2) years.

6. "**Illegal use of illicit or controlled substances**" means the use of substances obtained illegally (e.g., heroin or cocaine) as well as the use of controlled substances that are not obtained pursuant to a valid prescription or not taken in accordance with the directions of a licensed health care practitioner.

| **QUESTIONS: Please respond to ALL questions. If you answer "YES" to any question, please attach a written explanation.** | **YES** | **NO** |
|---|---|---|
| 1. Do you currently have any physical or psychological limitations or impairments caused by an existing medical condition which are reduced or ameliorated by ongoing treatment or monitoring, or the field of practice, the setting or the manner in which you have chosen to practice? | ___ | ___ |
| 2. Do you currently use any chemical substances which in any way impair or limit your ability to practice your profession with reasonable skill and safety? | ___ | ___ |

If so, please list: _____

*[If you receive such ongoing treatment or participate in such a monitoring program, the Board will make an individual assessment of the nature, the severity, and the duration of the risks associated with an ongoing medical condition so as to determine whether an unrestricted license should be issued, whether conditions should be imposed, or whether you are not eligible for licensure.]*

## COMPETENCY INFORMATION
**(continued)**

| **QUESTIONS: Please respond to ALL questions. If you answer "YES" to any question, please attach a written explanation.** | **YES** | **NO** |
|---|---|---|
| 3. At any time within the past two years, have you engaged in the illegal use of illicit or controlled substances? | ___ | ___ |
| 4. Are you currently participating in a supervised rehabilitation program or professional assistance program that monitors you in order to assure that you are not engaged in the illegal use of illicit or controlled substances? | ___ | ___ |
| 5. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, voyeurism or other diagnosis of a predatory nature? | ___ | ___ |
| 6. Have you ever held or applied for a license, privilege, registration or certificate to practice dentistry in any state, country, or province, that has been or was ever denied, reprimanded, suspended, restricted, revoked, otherwise disciplined, curtailed, or voluntarily surrendered under threat of investigation or disciplinary action? | ___ | ___ |
| 7. Have you ever had staff privileges at any hospital or health care facility that were ever revoked, suspended, curtailed, restricted, limited, otherwise disciplined, or voluntarily surrendered under threat of restriction or disciplinary action? | ___ | ___ |
| 8. Have you ever applied for or held a state or federal controlled substance certificate that was ever denied, revoked, suspended, restricted, voluntarily surrendered or otherwise disciplined or surrendered under threat of restriction or disciplinary action? | ___ | ___ |
| 9. Have you ever been convicted (including a nolo contendere plea or guilty plea) of a felony or misdemeanor (other than a minor traffic offense) whether or not sentence was imposed or suspended? | ___ | ___ |
| 10. Have you ever been rejected or censured by a professional association or society? | ___ | ___ |
| 11. In relation to the performance of your professional services in any profession: | | |
| a. Have you ever had a final judgment rendered against you; | ___ | ___ |
| b. Have you ever entered into any settlement of any legal action; or | ___ | ___ |
| c. Are there any legal actions pending against you or to which you are a party? | ___ | ___ |
| 12. Have you ever held a license, registration, privilege or certificate in any profession that has ever been reprimanded, suspended, restricted, revoked, otherwise disciplined, curtailed, or voluntarily surrendered under threat of investigation or disciplinary action in any jurisdiction? | ___ | ___ |
| 13. My name has been placed on the registry of persons who have abused, neglected or misappropriated the property of vulnerable individuals (Tennessee abuse registry or an abuse registry in another state) | ___ | ___ |
| 14. Have you ever been dropped, suspended, expelled, or disciplined by any school or college for any cause? | ___ | ___ |
| 15. Have you ever failed a dental examination? (National Boards, regional or state) | ___ | ___ |
| If yes, which exam and how many times have you failed? _____ | | |

**APPLICANT: FILL OUT THE FOLLOWING AFFIDAVIT**

## AFFIDAVIT AND RELEASE

I, _____, of _____,
*(Applicant's Name)* *(City)* *(State)*
being duly sworn and identified as the person referred to in this application attests to the truth of each statement made in said application. I further swear that I have read and understand the law and the Rules and Regulations regarding the practice of my profession, which are posted on the Board's Internet site and/or were provided to me by the Board office, and agree to abide by them in the practice as a dental hygienist in the State of Tennessee.

**I HEREBY:**

**SIGNIFY** my willingness to appear to answer such questions as the Board may find necessary, which may include a full Board interview.

**RELEASE** to the Board, its staff, and their representatives, any and all documentation necessary now and in the future to establish my physical and mental capabilities to safely practice as a dental hygienist.

**AUTHORIZE** the Board, its staff, and their representatives to consult with my prior and current associates and others who may have information bearing on my professional competence, character, health status, ethical qualifications, ability to work cooperatively with others, and other qualifications.

**RELEASE** from liability the Board, its staff, and all their representatives and any and all organizations which provide information for their acts performed and statements made in good faith and without malice concerning my competence, ethics, character, and/or other qualifications, for certification.

**ACKNOWLEDGE** that I, as an applicant for licensure, have the burden of producing adequate information for a proper evaluation of my professional, ethical, and other qualifications, and for resolving any doubts about such qualifications.

**AUTHORIZE** release, use and disclosure of otherwise HIPAA protected health information to the limited extent necessary for my application to receive full consideration up to and including discussion in a public forum should that become necessary.

**THIS CERTIFIES THAT THE INFORMATION SUBMITTED BY ME IN THIS APPLICATION IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF.**

_____ _____
**SIGNATURE** **DATE**