FLORIDA
DEPARTMENT OF HEALTH

BOARD OF DENTISTRY

DENTAL HYGIENE
LICENSURE APPLICATION

Department of Health
Florida Board of Dentistry
4052 Bald Cypress Way, #C-08
Tallahassee, FL 32399-3258
(850) 245-4474 Telephone – (850) 921-5389 Fax
http://www.floridasdentistry.gov/
Email: info@floridasdentistry.gov

Dental Hygiene Licensure Application Instructions

Applicants are strongly encouraged to review s. 466.007, Florida Statutes and Chapter 64B5-2, Florida Administrative Code, prior to submitting the application. Links to these documents are located at www.floridasdentistry.gov.

EXAMINATION REQUIREMENTS:

- Successful completion of the National Board Dental Hygiene Licensing Examination prior to application (Graduates from non-accredited dental schools may submit proof of successful completion of Parts I and II National Board Dental Exam or National Board Dental Hygiene Exam)
- Successful completion of the ADEX Dental Hygiene Licensing Examination in its entirety
- Successful completion of the state Laws and Rules Examination

Applicants must apply for the Florida Laws and Rules examination with The Commission on Dental Competency Assessments (CDCA). Please visit www.cdcaexams.org to register.

EDUCATIONAL REQUIREMENTS:

GRADUATION from a Dental/Dental Hygiene school accredited by the Commission on Dental Accreditation of the American Dental Association (A.D.A.); or

GRADUATION from a dental school not accredited by the Commission on Dental Accreditation of the American Dental Association; must have completed four (4) academic years of postsecondary dental education and possess a dental school diploma which is comparable to a D.D.S. or D.M.D. degree. Transcripts must be translated into English, and we must receive a subject analysis evaluation report from Educational Credential Evaluators, Inc.

Effective January 1, 2009, s. 466.007, F.S. states that applicants graduating from a dental school not accredited by the Commission on Dental Accreditation of the American Dental Association may be required to complete additional coursework only after failing the initial examination. (Reference Rule 64B5-2.0144, Florida Administrative Code)

FEES:

Application fee	$	50.00
Licensure fee		105.00*
TOTAL FEE	**$**	**155.00**

*Licensure fee is $55 for applicants applying in the second year of the biennium. All initial licenses expire February 28 of the following even numbered year. Licensure biennium dates are March 1 – February 28 of the even years.

The fee must accompany the application. Please make check or money order payable to the **Department of Health** and mail application with fee and supporting documentation and credentials to:

DEPARTMENT OF HEALTH
P.O. BOX 6330
TALLAHASSEE, FLORIDA 32314-6330

Any supporting documentation and credentials mailed separately from the application should be mailed to:

DEPARTMENT OF HEALTH
BOARD OF DENTISTRY
4052 BALD CYPRESS WAY, BIN #C08
TALLAHASSEE, FLORIDA 32399-3258

REFUNDS

The application fee is non-refundable. Applicants who require board approval will be scheduled for an appearance at the next board meeting.

If an application is received without the fee attached, the application will automatically be returned. A social security number issued by the Federal Government is required for licensure. After completing the application, double check to make sure you have marked all questions as "yes" or "no" or not applicable. Also be sure to sign and date the application. If you answered, "yes" to question(s) 3A-C, 4A-E, and/or 9A-F, please submit all supporting documentation with the application.

CREDENTIALS:

All credentials must be mailed to the Board of Dentistry office at 4052 Bald Cypress Way, BIN #C08 Tallahassee, Florida 32399-3258.

(1) **National Board Score:** The Board office must receive proof of successful completion of the National Board Dental Hygiene or Dental Examination. The scores must be mailed to our office from the American Dental Association.

(2) **Final Official Transcript:** Transcripts mailed to the Board of Dentistry by the registrar's office with appropriate stamps, seals, degree, and signatures are necessary. ALL final transcripts must indicate the matriculation date, graduation date, degree earned, and be embossed with the school seal. We will not accept any transcript that has "issued to student" stamped on the transcript. Any transcript, which does not conform to these standards, shall be deemed unofficial and unacceptable.

(3) **Certification of Licensure:** Please submit certification of licensure from each state in which you **HOLD OR HAVE HELD** a dental or dental hygiene license. This certification should state that your license is in good standing; appropriate signatures and embossed seal of the certifying Board are needed for validation.

(4) **Prevention of Medical Errors Requirement:** Each applicant must complete a minimum two hour course in the prevention of medical errors from a Board of Dentistry approved provider. "Proof of completion" of this course must be in the form of a certificate or letter from the provider and must be completed within the past two years. Information regarding providers and courses can be viewed at **www.cebroker.com**.

(5) CPR Certification: Each applicant must provide proof of training in cardiopulmonary resuscitation (CPR) at the basic support level, including one-rescuer and two rescuer CPR for adults, children, and infants; the use of an automatic external defibrillator (AED); and the use of ambu-bags. All such training shall be sufficient for and shall result in current certification or recertification by the American Heart Association, the American Red Cross or an entity with equivalent requirements.

(6) Other: If you have changed your name in any way or added or deleted part of your name from the time you started your dental education, you must submit a copy of your name change document. If you do not have a name change document filed with the courts, submit a notarized affidavit stating the names are one and the same. Please notify the board office if you have documents being sent to us in another name.

If any question in section 3A-B, 4A-E, and/or 9A-F on the application is answered “yes”, you must send all documentation filed with the courts, all letters/correspondence from the attorney explaining your situation, all letters from treating physicians, all information pertaining to any board of dentistry action taken against your license in another state, and any other information/documentation considered appropriate.

FLORIDA DEPARTMENT OF HEALTH DIVISION OF MEDICAL QUALITY ASSURANCE BOARD OF DENTISTRY	APPLICATION FOR DENTAL HYGIENE LICENSURE	DO NOT WRITE IN THIS SPACE FOR OFFICE USE ONLY
Date of ADEX Dental Hygiene Exam _____ Exam Site Location _____		
1. APPLICANT PROFILE DATA	➢Please attach cashier's check or money order ➢Please print or type or Application will be returned	

Name:	Last First Middle	Primary Telephone: Area Code ( )	Business Telephone: Area Code ( )
Mailing Address	Street and No. Apt. No.	Social Security Number Required; enter on Page 9	
	City State Zip	Place of Birth: (City, State, Country)	
Practice Location	Street and No. Apt. No.	Have you ever changed your name through marriage or through action of a court, or have you ever been known by any other name? Yes No	
	City State Zip	If yes, list name(s) and date(s) of change(s) below:	

Height Weight Eye Color Hair Color

E-mail address (optional)

We are required to ask that you furnish the following information as part of your voluntary compliance with Section 2, Uniform Guidelines on Employee Selection Procedure (1978) 43 FR38296 (August 25, 1978). This information is gathered for statistical and reporting purposes only and does not in any way affect your candidacy for licensure.

RACE: Caucasian African-American Hispanic Asian Native American Other

SEX: Male Female

DATE OF BIRTH / /

2. APPLICANT EDUCATION AND EXAMINATION DATA

A. Name of Dental Hygiene or Dental School you attended:	
Location City State Country	Did you Graduate? Yes No Results Pending Degree: Year graduated:

B. Other Colleges or Universities:

Location From (Date)_____To: (Date) _____ Did you graduate? Degree:

➢ A final official transcript sent DIRECTLY from your school of Dentistry or Dental Hygiene **must be received by the Board of Dentistry** to be approved for licensure.

C–1. Have you successfully completed the National Board Dental Examination? (applicants from unaccredited schools)

Yes No Results Pending - If it is under another name, please give other name_____

C–2. Have you successfully completed the National Board Dental Hygiene Examination?

Yes No Results Pending - If it is under another name, please give other name _____

➢ These results must be sent directly from the National Board of Dental Examiners to the Florida Board of Dentistry. The contact information is: 211 East Chicago Avenue, Chicago, Illinois 60611, (312) 440-2811.

Staple two 2x2 photos here

3. APPLICANT HISTORY – GENERAL (ATTACH ADDITIONAL SHEETS IF NECESSARY)

A. Have you ever been convicted of, or entered a plea of guilty, nolo contendere, or no contest to a crime in any jurisdiction other than a minor traffic offense? You must include all misdemeanors and felonies, even if adjudication was withheld by the court so that you would not have a record or conviction. Driving under the influence or driving while impaired is not a minor traffic offense for purposes of this question.

➢ If yes, please list date, jurisdiction (state and county), offense, disposition, and all other relevant information on reverse side or an attached sheet and mail disposition papers to the Board office. Circle Yes No

B. IMPORTANT NOTICE: Applicants for licensure, certification or registration and candidates for examination may be excluded from licensure, certification or registration if their felony conviction falls into certain timeframes as established in Section 456.0635(2), Florida Statutes. If you answer YES to any of the following questions, please provide a written explanation for each question including the county and state of each termination or conviction, date of each termination or conviction, and copies of supporting documentation to the address below. Supporting documentation includes court dispositions or agency orders where applicable.

1. Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under Chapter 409, F.S. (relating to social and economic assistance), Chapter 817, F.S. (relating to fraudulent practices), Chapter 893, F.S. (relating to drug abuse prevention and control) or a similar felony offense(s) in another state or jurisdiction? **(If you responded "no", skip to #2.)** Yes No

a. **If "yes" to 1,** for the felonies of the first or second degree, has it been more than 15 years from the date of the plea, sentence and completion of any subsequent probation? Yes No

b. **If "yes" to 1,** for the felonies of the third degree, has it been more than 10 years from the date of the plea, sentence and completion of any subsequent probation? (This question does not apply to felonies of the third degree under Section 893.13(6)(a), Florida Statutes). Yes No

c. **If "yes" to 1,** for the felonies of the third degree under Section 893.13(6)(a), Florida Statutes, has it been more than 5 years from the date of the plea, sentence and completion of any subsequent probation? Yes No

d. **If "yes" to 1,** have you successfully completed a drug court program that resulted in the plea for the felony offense being withdrawn or the charges dismissed? (If "yes", please provide supporting documentation). Yes No

2. Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under 21 U.S.C. ss. 801-970 (relating to controlled substances) or 42 U.S.C. ss. 1395-1396 (relating to public health, welfare, Medicare and Medicaid issues)? Yes No

a. **If "yes" to 2,** has it been more than 15 years before the date of application since the sentence and any subsequent period of probation for such conviction or plea ended? Yes No

3. Have you ever been terminated for cause from the Florida Medicaid Program pursuant to Section 409.913, Florida Statutes? **(If "No", do not answer 3a.)** Yes No

a. If you have been terminated but reinstated, have you been in good standing with the Florida Medicaid Program for the most recent five years? Yes No

4. Have you ever been terminated for cause, pursuant to the appeals procedures established by the state from any other state Medicaid program **(If no, do not answer 4a or 4b.)** Yes No

a. Have you been in good standing with a state Medicaid program for the most recent five years? Yes No

b. Did the termination occur at least 20 years prior to the date of this application? Yes No

5. Are you currently listed on the United States Department of Health and Human Services Office of Inspector General's List of Excluded Individuals and Entities? Yes No

6. If "yes" to any of the questions 1 through 5 above, on or before July 1, 2009, were you enrolled in an educational or training program in the profession in which you are seeking licensure that was recognized by this profession's licensing board or the Department of Health? (If "yes", please provide official documentation verifying your enrollment status.) Yes No N/A

4. APPLICANT HISTORY – PROFESSIONAL LICENSURE

A. Have you ever been denied the right to take a Dental or Dental Hygiene examination in any state? Yes No

B. Have you ever been refused a license to practice Dentistry, Dental Hygiene or any other license – or the renewal thereof in any state? Yes No

C. Have you ever had a license revoked or a certificate of registration to practice Dentistry, Dental Hygiene or any other licensed profession revoked, suspended or otherwise acted against (including probation, fine or reprimand) in a disciplinary proceeding in any state? Yes No

D. Are you now or have you ever been a defendant in civil litigation in which the basis of the complaint against you was in alleged negligence, malpractice or lack of professional competence? Yes No

E. Is there currently pending against you in any jurisdiction a complaint against your professional conduct or competence as a Dentist or Dental Hygienist? Yes No

- If Questions 4A, 4B, 4C, 4D or 4E above are answered "YES", you must provide complete details as to state(s), license number(s), dates, and relevant circumstances on reverse side or on attached sheets.

5. APPLICANT LICENSURE STATUS

A. Do you now hold or have you ever held a license to practice Dentistry or Dental Hygiene in any state, U.S. territory or foreign country? (List most recent first) Yes No If "YES", list ALL such licenses below

State: License # If license is not in force, how and when was validity ceased?

B. Do you have any applications for Dental or Dental Hygiene Licensure currently pending in any state or foreign country? Yes No If "YES", list ALL such state or jurisdictions below

6. OATH

I hereby authorize all hospitals, institutions or organizations, my references, 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 the Florida Department of Health my information files or records requested by the department in connection with the processing of this application. I further authorize the Florida Department of Health to release to the organizations, individuals and groups listed above, any information which is material to my application. I understand that it is my responsibility to supplement my application as needed to reflect any material changes in any circumstance or condition stated in the application which might affect the decision of the department and which takes place between the initial filing of the application and the final granting or denial of licensure. I understand that the application fee is non-refundable.

I have carefully read the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for the denial, suspension, or revocation of any license to practice in the State of Florida the profession for which I am applying.

Applicant Signature _____ Date _____

STATE OF _____ COUNTY OF _____

Before me, personally appeared _____, whose identity is known to me by _____ (type of identification) and who, under oath, acknowledges that his signature appears above.

Sworn to and subscribed before me this _____ day of _____. 20_____.

_____ NOTARY PUBLIC

My Commission Expires:

7. REMARKS

This section is for any additional information you would like to give us. Please refer to the section number (within the application) you are referring to. An example would be: #1, Applicant Profile Data.

CONFIDENTIAL AND EXEMPT FROM PUBLIC RECORDS DISCLOSURE*

Florida Department of Health
Board of Dentistry

8. Name: _____
Last First Middle

Social Security Number: _____

*This page is exempt from public records disclosure. The Department of Health is required and authorized to collect Social Security Numbers relating to applications for professional licensure pursuant to Title 42 USCA s. 666(a)(13). For all professions regulated under chapter 456, Florida Statutes, the collection of Social Security Numbers is required by section 456.013(1)(a), Florida Statutes.

9. - APPLICANT HISTORY - HEALTH

If you answer "YES" to any of the following questions, you must submit a current mental health status report from a licensed mental health professional, wherein this professional practitioner opines that you are able to practice with reasonable skill and safety to patients or clients.

A. In the last 5 years, have you been enrolled in, required to enter into, or participated in any drug or alcohol recovery program or impaired practitioner program for treatment of drug or alcohol abuse that occurred within the past 5 years?	❑ YES ❑ NO
B. In the last 5 years, have you been admitted or referred to a hospital, facility or impaired practitioner program for treatment of a diagnosed mental disorder or impairment?	❑ YES ❑ NO
C. During the last 5 years, have you been treated for or had a recurrence of a diagnosed mental disorder that has impaired your ability to practice your profession within the past 5 years?	❑ YES ❑ NO
D. In the last 5 years, were you admitted or directed into a program for the treatment of a diagnosed substance-related (alcohol/drug) disorder or, if you were previously in such a program, did you suffer a relapse within the last 5 years?	❑ YES ❑ NO
E. During the last 5 years, have you been treated for or had a recurrence of a diagnosed substance-related (alcohol/drug) disorder that has impaired your ability to practice your profession within the past 5 years?	❑ YES ❑ NO
F. During the last 5 years, have you been treated for or had a recurrence of a diagnosed physical disorder that has impaired your ability to practice your profession?	❑ YES ❑ NO

CERTIFICATE OF LICENSURE

Instructions: For your convenience, you may tear out this page and send it to the Secretary of the Board in the state(s) where you hold or have held a license. However, only certificates bearing the ORIGINAL signature of certifying authorities will be accepted by the Florida Board of Dentistry.

CERTIFICATION OF SECRETARY OF BOARD OF THE STATE
IN WHICH APPLICANT HOLDS OR HAS HELD A
DENTAL/DENTAL HYGIENE LICENSE
(Required of all previously licensed candidates)

I, _____

Secretary of _____
Official name of Board

hereby certify that _____was granted State Certificate No. _____

to practice ☐ Dentistry ☐ Dental Hygiene in the state of _____

on the _____ day of _____, 20_____, on the basis of _____

- I hereby certify that the said applicant is in good standing with this board and there have not been any disciplinary procedures against, or pending on, said applicant.

(SEAL)
NOT VALID WITHOUT
STATE SEAL

_____
Secretary

- If disciplinary action has been taken, please indicate, and submit supporting information.

CERTIFICATION OF COURSE COMPLETION FOR PREVENTION OF MEDICAL ERRORS REQUIREMENT FOR DENTAL HYGIENE APPLICANTS

PLEASE MARK ONE

Applicant's Name: _____

Name should be the same as stated in exam application

Provider Name: _____

Provider Address: _____

Title of Course: _____

Date of Course: _____

Number of credit hours offered: _____

_____ _____

Signature of Authorized Agent Date