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.

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. Applicant must have completed four (4) academic years of post-secondary 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.

Section 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

<table>
<thead>
<tr>
<th>Fee</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unlicensed Activity fee</td>
<td>5.00</td>
</tr>
<tr>
<td>Application fee</td>
<td>50.00</td>
</tr>
<tr>
<td>Licensure fee</td>
<td>80.00*</td>
</tr>
<tr>
<td><strong>TOTAL FEE</strong></td>
<td><strong>$135.00</strong></td>
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</tbody>
</table>

*Licensure fee is $40 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
BOARD OF DENTISTRY
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 CYPRUS 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) 5, 6, 7 and/or 11, 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 Joint Commission on National Dental Examinations.

(2) **Final Official Transcript**: Dental transcripts shall be sent to the Board of Dentistry by the registrar’s office. 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) **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.

(5) **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.
Staple two photos in this area. Do not glue or paste.

Dental Hygiene Licensure Application
PO Box 6330
Tallahassee, FL 32314-6330
Phone: (850) 245-4474
Fax: (850) 921-5389

Please complete this application in its entirety prior to submitting

Fees must be paid in the form of a cashier’s check or money order, made payable to: DOH Florida Board of Dentistry

1. Examination History
   Date of ADEX Exam: ___________________ Location of ADEX Exam: ___________________

2. Application Profile Data
   Name: ____________________________________________ Date of Birth: ____________
   Last                                           First                                      Middle                       MM/DD/YYYY

   Mailing Address: (Give the address where mail and your license should be sent)
   Street/PO Box __________________________ Apt. No. __________ City __________________________
   State ____________ Zip __________ Country __________________________ Primary Telephone __________

   Physical Location: (Required if mailing address is a P.O. Box- This address will be posted on the Department of Health’s website.)
   Street __________________________ Apt./Suite No. __________ City __________________________
   State ____________ Zip __________ Country __________________________ Secondary Telephone __________

   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
   If yes, list name(s) and date(s) of change(s): ________________________________________________

   Email Notification: If you want to be notified of the status of your application by email please check the “Yes” box and write your email address on the line provided below. If you choose this form of notification, you will receive information regarding your application file through email. You will be responsible for checking your email regularly and updating your email address with the Board office.
   Email Address: ___________________________________________________

   Under Florida law, email addresses are public records. If you do not want your e-mail address released in response to a public records request, do not provide an email address or send electronic mail to our office.

   Equal Opportunity Data: We are required to ask that you furnish information as part of your voluntary compliance with Section 2, Uniform Guidelines on Employee Selection Procedure (1978) 43 CFR 38295 and 38296 (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: ☐ White ☐ Black or African American ☐ Asian ☐ American Indian or Alaska Native ☐ Hispanic ☐ Two or More Races
3. Applicant Education and Examination Data

Dental or Dental Hygiene School Attended: ______________________ City: _____________ State: _________

Degree: __________________________ Date Graduated/Anticipated Graduation: ________________________

Official transcripts including degree and date of graduation must be sent DIRECTLY from your school to the Board of Dentistry before your application can be deemed complete.

Have you successfully completed the National Board Dental Exam?  □ Yes  □ No

Have you successfully completed the National Board Dental Hygiene Exam?  □ Yes  □ No

If taken under another name, please provide: ______________________________

These results must be sent directly from The Joint Commission on National Dental Examinations to the Florida Board of Dentistry. The contact information is: 211 East Chicago Avenue, Chicago, Illinois 60611, (800) 440-2811.

4. Applicant Education and Examination Data

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

State/Jurisdiction License No. If no longer licensed, state why and when
__________________________________________
__________________________________________
__________________________________________
__________________________________________
__________________________________________
__________________________________________

5. Criminal History

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 you answered “Yes” to the question above you are required to send the following items:
□ Self Explanation describing in detail the circumstances surrounding each offense; including dates, city and state, charges and final results.
□ Final Dispositions and Arrest Records for all offenses. The Clerk of the Court in the arresting jurisdiction will provide you with these documents. Unavailability of these documents must come in the form of a letter from the Clerk of the Court.
□ Completion of Sentence Documents. You may obtain documents from the Department of Corrections. The report must include the start date, end date and that the conditions were met.
6. Criminal and Health Care Fraud Questions

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 “no”, skip to #2.**
   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)?  
   **If “no”, skip to #3.**
   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”, skip to #4.**
   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, skip to #5.**
   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

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7. Applicant History – Professional Licensure – If any below questions are answered “YES”, you must provide complete details as to state(s), license number(s), dates, and relevant circumstances on attached sheets.

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

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

Have you ever had a license 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

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

In any jurisdiction, do you have a pending complaint against your professional conduct or competence as a Dentist or Dental Hygienist?  
□ Yes ☐ No
8. Oath/Verification of Document

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.

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.

Under penalties of perjury, I declare that I have read the foregoing Dental Hygiene Licensure Application and that the facts stated in it are true.

Applicant Signature ________________________________________ Date ______________________

9. 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: #2, Applicant Profile Data.

________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
CONFIDENTIAL AND EXEMPT FROM PUBLIC RECORDS DISCLOSURE*

10. Name:  

Social Security Number:  

Last  

First  

Middle  

*Pursuant to 42 U.S.C. § 666(a)(13), the department is required and authorized to collect Social Security Numbers relating to applications for professional licensure. Additionally, section 456.013(1)(a), Florida Statutes, authorizes the collection of Social Security Numbers as part of the general licensing provisions. This information is exempt from public records disclosure.

11. Applicant Health History - 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.

1. Do you have any condition that currently impairs your ability to practice your profession with reasonable skill and safety?  

☐ Yes  ☐ No  

2. Are you using medications, other drugs, narcotics, or intoxicating chemicals that impair your ability to practice your profession with reasonable skill and safety?  

☐ Yes  ☐ No  

If you answered "yes" to either of the above questions, please provide a letter from a licensed health care practitioner, who is qualified by skill and training to address your condition, which explains the impact your condition may have on your ability to practice your profession with reasonable skill and safety, and stating either that you are safe to practice your profession without restriction or indicating what restrictions are necessary. If necessary, you may attach additional sheets. Documentation must be current within the last year. If you fail to disclose the information requested in this section, your application may be denied.
**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.

<table>
<thead>
<tr>
<th>CERTIFICATION OF SECRETARY OF BOARD OF THE STATE</th>
<th>IN WHICH APPLICANT HOLDS OR HAS HELD A DENTAL/DENTAL HYGIENE LICENSE</th>
<th>(Required of all previously licensed candidates)</th>
</tr>
</thead>
<tbody>
<tr>
<td>I,</td>
<td>Secretary of __________________________________________________________</td>
<td>Official name of Board</td>
</tr>
<tr>
<td>Hereby certify that _________________________ was granted State Certificate No. _____________</td>
<td>to practice □ Dentistry □ Dental Hygiene in the state of ______________________</td>
<td></td>
</tr>
<tr>
<td>on the _____________ day of ________<em><strong><strong>, 20</strong></strong></em>, on the basis of ____________________</td>
<td></td>
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</tr>
<tr>
<td>➢ 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.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(SEAL) NOT VALID WITHOUT STATE SEAL</td>
<td>Secretary</td>
<td></td>
</tr>
<tr>
<td>➢ If disciplinary action has been taken, please indicate, and submit supporting information.</td>
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