



The Commonwealth of Massachusetts  
Division of Health Professions Licensure  
**Board of Registration in Dentistry**  
239 Causeway Street, 5th Floor, Suite 500  
Boston, MA 02114  
(617) 973-0971  
[www.mass.gov/dph/boards/dn](http://www.mass.gov/dph/boards/dn)

## DENTAL HYGIENE LICENSURE BY CREDENTIALS

(See 234 CMR 4.08 Effective August 20, 2010)

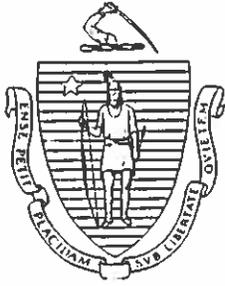
### Applicant Instructions

The Board may grant a license by credentials to a dental hygienist currently licensed in another jurisdiction who has practiced one (1) year or more provided that the applicant is of good moral character, has met all of the eligibility requirements, and has submitted the following information and documentation to the Board:

- An accurate, complete and signed application including CORI request form.
- Payment of a nonrefundable, nontransferable licensing fee.
- An original transcript with the college seal indicating the degree granted and the date of issue from a CODA-accredited dental hygiene program, or a letter including the college's seal which is signed by the appropriate authority and attests to the applicant's degree and date of graduation.
- A physician's statement that is the result of an examination, conducted within six months of the date of application, attesting to the health of the applicant and to any impairments which may affect the ability of the applicant to practice dentistry.
- Proof satisfactory to the Board of a minimum of one year of practice in dental hygiene or dental hygiene education immediately preceding the application for licensure by credentials.
- Proof satisfactory to the Board that the applicant is currently licensed and in good standing in another jurisdiction based on successful completion of a regional exam.
- Documentation of a passing score on each of the following examinations:
  - (a) The American Dental Association National Board Examination for Dental Hygienists; and
  - (b) Massachusetts Dental Ethics and Jurisprudence Examination. Email the Board at [dentistry.admin@state.ma.us](mailto:dentistry.admin@state.ma.us) to request a copy of the exam.
- Certified letters of standing from all jurisdictions in which the applicant has ever been issued a license to practice dental hygiene attesting to the standing of his/her license including a report of any past or pending disciplinary action, or any pending complaints against the applicant.
- Documentation demonstrating current certification in American Red Cross Cardiopulmonary Resuscitation/Automated External Defibrillation for the Professional Rescuer (CPR/AED) or current certification in the American Heart Association Basic Life Support for Healthcare Providers (BLS).
- A statement disclosing any disciplinary, civil and/or criminal action taken against the applicant at any time prior to the date of application, with supporting documentation as may be required by the Board.
- Attach a passport-size photograph in color (2x2) to application where indicated. See [http://travel.state.gov/passport/guide/composition/composition\\_874.html](http://travel.state.gov/passport/guide/composition/composition_874.html)
- Proof satisfactory to the Board of good moral character. Provide signatures from two (2) licensed dentists (who do not need to be licensed in Massachusetts) familiar with the character and quality of the applicant. Immediate family members or close relatives do not qualify.
- An affidavit, signed under pains and penalties of perjury, and witnessed by a Notary Public.
- Proof of 20 units of continuing education obtained 24 months prior to application.

#### Please Note:

- Incomplete applications will delay licensure processing.
- Please retain a copy of all application submissions for your records.
- Confirmation of your license number will be available under "Online services/Check a License" on our website [www.mass.gov/dph/boards/dn](http://www.mass.gov/dph/boards/dn) as soon as the Board approves the license.



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**BOARD USE ONLY**

Receipt # \_\_\_\_\_

Fee : \_\_\_\_\_

Jurisprudence: Pass \_\_\_\_\_ Fail \_\_\_\_\_

**APPLICATION --DENTAL HYGIENE BY CREDENTIALS**

1. APPLICANT NAME:

(Last)

(First)

(Middle)

2. MAIDEN NAME OTHER NAME:

3. ADDRESS OF RECORD:

(No.)

(Street)

(Apt #)

(City)

(State or Country)

(Zip Postal Code)

Note: The address of record may be home or business and is public information

4. MOST RECENT PREVIOUS ADDRESS:

5. TELEPHONE NUMBER AND EMAIL ADDRESS: Day:

Cell:

Email Address:

6.

Date of Birth (mm dd yyyy)

Place of Birth (city state country)

EYE COLOR:

HEIGHT: Feet Inches WEIGHT: Lbs. MOTHER'S MAIDEN NAME:

7. SOCIAL SECURITY NUMBER (SSN) (disclosure is mandatory):

Pursuant to M.G.L. c. 62C, s. 47A, the Division of Health Professions Licensure is required to obtain your SSN and forward it to the Massachusetts Department of Revenue. The Department of Revenue will use your SSN to ascertain whether or not you are in compliance with Massachusetts tax laws (M.G.L. c. 62C, s. 47A) and child support laws (M.G.L. c. 119A, s.16).

## EDUCATION

8. GRADUATE OF:

Name of Dental Hygiene School

City, State, Postal Code, Country

9. DATE DIPLOMA OR CERTIFICATE CONFERRED

DATE

DEGREE

MM DD YYYY

**AN OFFICIAL TRANSCRIPT OR ORIGINAL LETTER FROM THE DEAN'S OFFICE CONFIRMING THE ABOVE INFORMATION MUST BE ATTACHED.**

10. REGIONAL OR STATE BOARD EXAMINATION (A COPY OF CERTIFICATE OR SCORES MUST BE ATTACHED TO THIS APPLICATION) PLEASE REFER TO THE BOARD'S WEBSITE [WWW.MASS.GOV/DPH/BOARDS/DN](http://WWW.MASS.GOV/DPH/BOARDS/DN) FOR MORE INFORMATION

CHECK HERE IF YOU HAVE TAKEN THE NERB  DATE OF EXAM

OTHER EXAMINATION

DATE OF EXAM

MM DD YYYY

11. NATIONAL BOARD CERTIFICATION: DATE COMPLETED

MM DD YYYY

## VERIFICATION OF OTHER LICENSES/BOARD REGISTRATIONS

12. LIST BELOW ALL PROFESSIONAL LICENSES OR REGISTRATIONS-- INCLUDING PROFESSIONS OTHER THAN DENTISTRY WHETHER OR NOT YOU HAVE PRACTICED UNDER THAT LICENSE OR REGISTRATION.

NOTE: Applicants must obtain official verification of each professional license or registration from each state or jurisdiction and submit it with this application.

I DO NOT CURRENTLY HOLD AND HAVE NEVER HELD A PROFESSIONAL LICENSE OR CERTIFICATION IN ANY STATE OR JURISDICTION

I CURRENTLY HOLD AND HAVE A PROFESSIONAL LICENSE OR REGISTRATION AS FOLLOWS:

Issuing Jurisdiction

Profession

License Certification Number

## GOOD MORAL CHARACTER QUESTIONS

IF YOU ANSWER "YES" TO ANY OF THE FOLLOWING QUESTIONS PLEASE ATTACH A SEPARATE SHEET EXPLAINING THE CIRCUMSTANCES AND ALL RELEVANT DOCUMENTATION INCLUDING FINAL DISPOSITION.

12. Have you ever applied for and been denied a professional license in the United States or any country or foreign jurisdiction?

Yes  No

13. Has any licensing or certification board, government authority, hospital or health care facility or professional medical association located in the United States or any country or foreign jurisdiction taken any disciplinary action against you?

Yes  No

14. Are you the subject of pending disciplinary actions by any licensing or certification board, government authority, hospital or health care facility or professional medical association located in the United States or any country or foreign jurisdiction?

Yes  No

15. Have you ever voluntarily surrendered any professional license or board certification in the United States or any country or foreign jurisdiction?

Yes  No

16. Have you ever been arrested, charged, arraigned, indicted, prosecuted, convicted or been the subject of any criminal investigation or any court proceeding in relation to any criminal violation? Do not report minor violations for which a fine of \$100 or less was imposed.

Yes  No

## RECOMMENDATIONS OF GOOD MORAL CHARACTER

WE, THE UNDERSIGNED, ARE PERSONALLY ACQUAINTED WITH \_\_\_\_\_, THE APPLICANT NAMED IN THE APPLICATION, AND RECOMMEND HIM/HER AS A PERSON OF GOOD MORAL CHARACTER.

1. PRINTED NAME \_\_\_\_\_ STATE AND LICENSE NUMBER \_\_\_\_\_  
ADDRESS \_\_\_\_\_  
SIGNATURE \_\_\_\_\_

2. PRINTED NAME \_\_\_\_\_ STATE AND LICENSE NUMBER \_\_\_\_\_  
ADDRESS \_\_\_\_\_  
SIGNATURE \_\_\_\_\_

RELEASE

I hereby authorize all hospitals, institutions, credentialing agencies, organizations, personal physicians, employers (past and present), business and dental associates (past and present), and all government agencies and entities (local, state, federal, or foreign) to release to the Board of Registration in Dentistry any information, files or records requested by the Board in connection with the processing of my application. I further authorize the Board of Registration in Dentistry to release information contained in this application in association with its processing.

**AFFIDAVIT OF APPLICANT**

To the best of my knowledge and belief, I have filed all state tax returns and paid all state taxes required by state law and do not owe child support. I am aware of my professional obligations under M.G.L. c. 119 s. 51A, the reporting of suspected child abuse.

I understand that the Board is certified by the Massachusetts Criminal History Systems Board for access to Criminal Offender Record Information (CORI), including conviction and pending criminal case data. As an applicant for a license to practice as a dental hygienist I understand that a CORI check may be conducted by the Board for conviction and pending criminal case information only and that the CORI results will not necessarily disqualify me.

I understand that I am responsible for reading and understanding the laws and regulations governing practice as a licensed dental hygienist in Massachusetts and I hereby agree to comply with such laws and regulations

I understand that this application for licensure as a dental hygienist shall be deemed no longer valid if requirements for licensure as a dental hygienist not met within one (1) year from the date of Board receipt. I also understand that fees are non-refundable and non-transferable.

I certify, under the pains and penalties of perjury, that the information I have provided pursuant to this application for licensure is truthful and accurate. I understand that any failure to provide truthful and accurate information in connection with this application for licensure may be grounds for the Board of Registration in Dentistry to deny issuance of a license; to suspend or revoke a license issued to me; and to deny renewal of a license issued to me, all in accordance with Massachusetts law.

**To be completed, signed and witnessed by the applicant and Notary Public.**

APPLICANT SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_

PRINT NAME \_\_\_\_\_

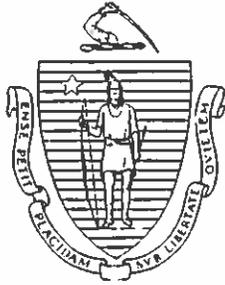
Attach a recent color  
2x2 passport  
photo

NOTARY NAME: \_\_\_\_\_

COMMISSION EXPIRES: \_\_\_\_\_

[Seal or Stamp]

**INCLUDE A NON-REFUNDABLE , NON-TRANSFERABLE FEE FOR \$126 (CHECK OR MONEY ORDER ) PAYABLE TO THE COMMONWEALTH OF MASSACHUSETTS**



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**CRIMINAL OFFENDER RECORD INFORMATION (CORI)**  
**ACKNOWLEDGEMENT FORM**

TO BE USED BY ORGANIZATIONS CONDUCTING CORI CHECKS FOR EMPLOYMENT, VOLUNTEER, SUBCONTRACTOR, LICENSING, AND HOUSING PURPOSES.

The Board of Registration in Dentistry is registered under the provisions of M.G.L. c. 6, § 172 to receive CORI for the purpose of screening current and otherwise qualified license applicants and current licensees.

As a prospective or current license applicant or current licensee, I understand that a CORI check will be submitted for my personal information to the Department of Criminal Justice Information Systems (DCJIS). I hereby acknowledge and provide permission to the Board of Registration in Dentistry to submit a CORI check for my information to the DCJIS. This authorization is valid for one year from the date of my signature. I may withdraw this authorization at any time by providing written notice of my intent to withdraw consent to a CORI check.

**FOR EMPLOYMENT, VOLUNTEER, AND LICENSING PURPOSES ONLY:**

The Board of Registration in Dentistry may conduct subsequent CORI checks within one year of the date this Form was signed by me provided, however, that Board of Registration in Dentistry must first provide me with written notice of this check.

By signing below, I provide my consent to a CORI check and acknowledge that the information provided on Page 2 of this Acknowledgement Form is true and accurate.

SIGNATURE

DATE

NOTE: The Board of Registration in Dentistry cannot accept this form unless it is either (1) signed in person at the Board's offices in the presence of a DHPL employee who has verified the applicant's identity through acceptable identification, or (2) signed in the presence of a notary public who has likewise verified identity and then mailed or hand-delivered to the Board's offices at the address set forth above.

**CRIMINAL OFFENDER RECORD INFORMATION (CORI)**  
**ACKNOWLEDGEMENT FORM**

SUBJECT INFORMATION: (An asterisk (\*) denotes a required field)

\*Last Name                      \*First Name                      Middle Name                      Suffix

Maiden Name (or other name(s) by which you have been known)

\*Date of Birth    Place of Birth

\*Last Six Digits of Your Social Security Number:                      -

Sex:                      Height:                      ft.                      in.                      Eye Color:                      Race:

Driver's License or ID Number:    State of Issue:

\_\_\_\_\_  
Mother's Full Name (Mother's Maiden Name)

\_\_\_\_\_  
Father's Full Name

Current and Former Addresses:

Street Number & Name                      City/Town                      State                      Zip

Street Number & Name                      City/Town                      State                      Zip

The above information was verified by reviewing the following form(s) of government-issued identification:

VERIFIED BY:

Name of Verifying DIHPL Employee (Please Print)

ON

Date

Signature of Verifying DIHPL Employee OR Notary Public

NOTARY NAME: \_\_\_\_\_

COMMISSION EXPIRES:

[Seal or stamp]

## ATTACHMENT CHECKLIST

*Your application cannot be processed without all of the following, as applicable:*

**Attachment 1: Licensing Fee** -Personal or business check or money order must be made payable to the Commonwealth of Massachusetts in the amount of \$126. All fees are nonrefundable and nontransferable. Please do not staple to the application.

**Attachment 2: Proof of Graduation** - Original transcript from an ADA-approved program with school seal indicating date and type of diploma issued **or** original signed letter from Dean's office indicating date of issuance of diploma must be included with application. Photocopy Not Accepted.

**Attachment 3: National Board Certification** -Submit a photocopy of certificate from the National Board.

**Attachment 4: Proof of Regional or State Clinical Examination** - Proof of successful completion of regional or state clinical examinations must be attached to the application. NERB exam scores are sent to the Board monthly therefore a copy of NERB certificate is not necessary.

**Attachment 5: Physician's Statement** - Examination and signed statement on physician's stationery certifying that the candidate is fit to practice dental hygiene must have been completed within 6 months of application.

**Attachment 6: Documentation of Current CPR/AED for the Professional Rescuer Certification or current BLS certification**

**Attachment 7: Massachusetts Dental Ethics and Jurisprudence Exam-Answer sheet only.**

**Attachment 8: Proof of Continuing Education Credits** – Copies certifying completion of 20 CEUs required for the 24 month period prior to application must be attached.

**Attachment 9: Letters of Standing** Verification of Professional Licensure from each state or jurisdiction in which you now hold or ever have held a license must be included in the application. The letter of verification of licensure must include the current status of the license, license number, the official seal of the jurisdiction's licensing Board and any disciplinary action taken. Photocopy of a license is not acceptable.

**Attachment 10: Practice History** - If you have ever practiced dentistry in another jurisdiction or state, please include an up- to-date resume or practice history, including employer's contact information and dates of employment.

**Attachment 11: National Practitioner Data Bank Self-Query** - (If you have ever held a professional healthcare license in the United States) To request a self-query please contact the Data Bank at 1-800-767-6732 or [www.npdb-hipdb.hrsa.gov](http://www.npdb-hipdb.hrsa.gov). The Data Bank will mail the report to you. Only an original report from NPDB will be accepted for this application.