The Commonwealth of Massachusetts
Bureau of Health Professions Licensure
Board of Registration in Dentistry
250 Washington Street
Boston, MA 02108
(617) 973-0971
www.mass.gov/dph/dentalboard

DENTAL HYGIENE LICENSURE BY CREDENTIAL

(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 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
- 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/dentalboard as soon as the Board approves the license.

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BOARD USE ONLY
Receipt #_____

Fee :_____

Jurisprudence: Pass _____ Fail _____

APPLICATION—DENTAL HYGIENE
BY CREDENTIAL

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. _____/_____/_____ _____ _____ EYE COLOR: _____
Date of Birth (mm/dd/yyyy) Place of Birth (city/state/country)

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 IF OTHER THAN NERB/CDCA) PLEASE REFER TO THE BOARD'S WEBSITE WWW.MASS.GOV/DPH/DENTALBOARD FOR MORE INFORMATION

CHECK HERE IF YOU HAVE TAKEN THE NERB/CDCA ☐ 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.

NOTE: An applicant for employment or for housing or an occupational or professional license with a sealed record on file with the commissioner of probation may answer 'no record' with respect to an inquiry herein relative to prior arrests, criminal court appearances or convictions. An applicant for employment or for housing or an occupational or professional license with a sealed record on file with the commissioner of probation may answer 'no record' to an inquiry herein relative to prior arrests or criminal court appearances. In addition, any applicant for employment or for housing or an occupational or professional license may answer 'no record' with respect to any inquiry relative to prior arrests, court appearances and adjudications in all cases of delinquency or as a child in need of services which did not result in a complaint transferred to the superior court for criminal prosecution.

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 ☐ No record ☐

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

The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Department of Public Health
Bureau of Health Professions Licensure
Board of Registration in Dentistry
250 Washington Street, Boston, MA 02108

CHARLES D. BAKER
Governor
KARYN E. POLITO
Lieutenant Governor

Tel: 617-973-0971
Fax: 617-973-0980
www.mass.gov/dph/dentalboard

MARYLOU SUDDERS
Secretary
MARGRET R. COOKE
Commissioner

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 BHPL 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 identity of the subject of this acknowledgement form was verified by reviewing the following form(s) of government-issued identification:

_____

_____

VERIFIED BY: _____ ON _____

Name of Verifying BHPL Employee or Notary Public (Please Print) Date

_____

Signature of Verifying BHPL 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** -Contact NBDE to have scores released to the Board via the NBDE secure portal. NBDE assesses a fee for this service.
- ☐ **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/CDCA exam scores are sent to the Board; therefore a copy of NERB/CDCA 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. The Data Bank will mail the report to you. Only an original report from NPDB will be accepted for this application.