

The Commonwealth of Massachusetts
Bureau of Health Professions Licensure

Board of Registration in Dentistry

239 Causeway Street, Suite 500

Boston, MA 02114

(617) 973-0971

www.mass.gov/dph/dentalboard

INITIAL DENTAL HYGIENIST LICENSURE BY EXAMINATION

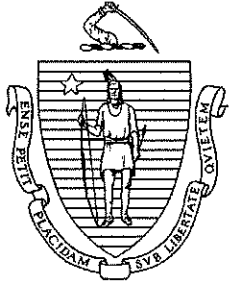
Applicant Instructions

The Board may grant a dental hygiene license to an applicant provided the applicant is of good moral character, has met all of the eligibility requirements, and has submitted the following documents:

- Payment of the nonrefundable, nontransferable \$126 licensing fee;
- An official, original transcript with the college seal indicating the date of graduation and degree awarded by a CODA-accredited dental hygiene program OR an official, original letter including the college's seal which is signed by the appropriate authority attesting to the applicant's date of graduation and degree awarded;
- A statement from the applicant's physician, nurse practitioner or physicians' assistant that is the result of a physical examination, conducted within one year 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 dental hygiene;
- Documentation of a passing score on each of the following examinations:
 - (a) The National Board Dental Hygiene Examination;
 - (b) Massachusetts Dental Ethics and Jurisprudence Examination; and
 - (c) A Board-recognized clinical competency exam such as the CDCA exam.Email the Board at dentistry.admin@state.ma.us to request a copy of its ethics exam;
- Certified letters of standing from all jurisdictions in which the applicant has ever been issued a license to practice dental hygiene or other profession 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;
- A color photograph, passport-sized (2 x 2) or larger;
- Proof satisfactory to the Board of good moral character. Provide signatures from two (2) licensed dentists or dental hygienists (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; and
- An affidavit signed and witnessed by a Notary Public.

Please Note:

- Incomplete applications will delay licensure processing.
- Please retain a copy of all application documents for your records.
- Confirmation of your license number will be available under "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 FOR
INITIAL LICENSURE AS A
DENTAL HYGIENIST -
BY EXAMINATION**

1. APPLICANT NAME: _____
(Last) (First) (Middle)

2. MAIDEN NAME/OTHER NAME: _____

3. ADDRESS OF RECORD: _____
(No.) (Street) (Apt #)

(Town) (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 Bureau 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 pursuant to M.G.L. c. 62C, s. 47A and child support laws pursuant to M.G.L. c. 119A, s.16.

EDUCATION

8. GRADUATE OF: _____
Name of Dental Hygiene School City, State, Zip Code

9. DATE OF GRADUATION AND DEGREE AWARDED YEAR _____ DEGREE _____
MM/DD/YYYY

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

10. NATIONAL DENTAL HYGIENE BOARD CERTIFICATION: DATE COMPLETED _____

11. REGIONAL OR STATE BOARD EXAMINATION (A COPY OF CERTIFICATE WITH SCORES OF ALL SECTIONS MUST BE ATTACHED TO THIS APPLICATION): PLEASE REFER TO THE BOARD'S WEBSITE AT WWW.MASS.GOV/DPH/DENTALBOARD FOR MORE INFORMATION ON BOARD-APPROVED EXAMS.

CHECK HERE IF YOU HAVE TAKEN THE CDCA/NERB DATE OF EXAM _____
MM/DD/YYYY

OTHER EXAMINATION _____ DATE OF EXAM _____
MM/DD/YYYY

VERIFICATION OF OTHER LICENSES/BOARD REGISTRATIONS

12. LIST BELOW ALL PROFESSIONAL LICENSES OR REGISTRATIONS INCLUDING PROFESSIONS OTHER THAN DENTISTRY OR DENTAL HYGIENE 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:

<u>Issuing Jurisdiction</u>	<u>Profession</u>	<u>License/Certification Number</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

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, regarding 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 my 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 the requirements for licensure as a dental hygienist are not met within one (1) year from the date of Board receipt. I also understand that all licensure fees are non-refundable and non-transferable.

I attest 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 the issuance of a license to me; to suspend or revoke a license issued to me; and to deny the renewal of a license issued to me, all in accordance with Massachusetts law.

APPLICANT SIGNATURE _____ DATE _____

PRINT NAME _____

Attach a recent color photo here (passport sized or larger)

NOTARY NAME: _____

COMMISSION EXPIRES: _____

[Seal or stamp]

MAKE SURE TO INCLUDE A NON-REFUNDABLE , NON-TRANSFERABLE PAYMENT OF \$126 (BY CHECK OR MONEY ORDER ONLY) MADE PAYABLE TO THE COMMONWEALTH OF MASSACHUSETTS WITH YOUR APPLICATION

ATTACHMENT CHECKLIST

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

- Attachment 1: Licensing Fee** - A personal check, business check or money order made payable to the Commonwealth of Massachusetts in the amount of \$126. All fees are non-refundable and non-transferable. Please do not staple your payment to the application.
- Attachment 2: Proof of Graduation** – An original, official transcript from a CODA-accredited dental hygiene program indicating your date of graduation and degree awarded **OR** an official, original letter signed by the dean or registrar indicating your date of graduation and degree awarded. Photocopies are not acceptable.
- Attachment 3: National Board Certification** – Include a copy of your National Dental Hygiene Board scores.
- Attachment 4: Proof of Regional or State Clinical Examination** - Proof of your successful completion of a Board-approved regional or state clinical examination must be included with your application. CDCA exam scores are available to the Board therefore a copy of your CDCA scores is not necessary. Refer to the Board's website at www.mass.gov/dph/dentalboard for more information on Board-approved examinations.
- Attachment 5: Physician's Statement** – A statement from your physician, nurse practitioner or physicians' assistant that is the result of a physical examination, conducted within one year of the date of application, attesting to your health and to any impairments that may affect your ability to practice dental hygiene.
- Attachment 6: Documentation of current CPR/AED for the Professional Rescuer certification or current Basic Life Support for Healthcare Providers certification.** Include a copy of both sides of your certification card.
- Attachment 7: Massachusetts Dental Ethics and Jurisprudence Exam** - Answer sheet only.

IF APPLICABLE:

- Attachment 8: Letters of Good Standing** – Verification of professional licensure from each state or jurisdiction in which you now hold or ever have held a license to practice dental hygiene or other profession must be included with your application. The letter of verification of licensure must include the current status of your license, your license number, the official seal and/or signature of the jurisdiction's licensing Board and whether any disciplinary action was taken. Photocopies of your other licenses are not acceptable.
- Attachment 9: Practice History** – An updated resume, curriculum vitae or practice history must be included with your application.
- Attachment 10: 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.