

**\*\*\*FOR OFFICE USE ONLY\*\*\***  
**Public Health Dental Hygienist Checklist**

App & Fee (\$65.00)

Valid Photo ID

Work and/or clinical experience

CEU Requirements

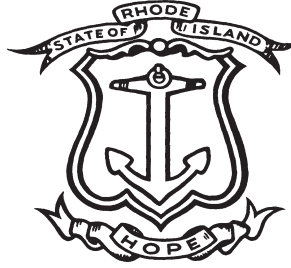
**Out of State**

Official Transcript

National Board Exam results

ADEX exam results

Verification from other state(s)



**\*\*\*FOR OFFICE USE ONLY\*\*\***

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

ID # \_\_\_\_\_

Issue Date \_\_\_\_\_

License # \_\_\_\_\_

**Rhode Island  
Board of Examiners in Dentistry**

Room 104  
3 Capitol Hill  
Providence, RI 02908-5097

***Instructions and  
License Application for:***

**Public Health Dental Hygienist**

**RI Dental Hygienist License**

# \_\_\_\_\_

Applicant - Print License Number

License # \_\_\_\_\_

Name \_\_\_\_\_

**MILITARY STATUS ELIGIBILITY** *(Documentation Required)  
see next page for instructions*

Please check ONE of the following criteria for expedited application:

I am in active military duty or a reservist

I am a military veteran with honorable discharge

I am the spouse of someone in active military duty or the spouse of a reservist

*Applicant - Print Name*

\_\_\_\_\_

**LAST NAME**

**FIRST NAME**

**MI**

**Phone: (401) 222-2828**

**TTY/TDD: (800) 745-5555**

**Fax: (401) 222-1272**

## LICENSURE REQUIREMENTS

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- Completed, Notarized Application with Cover Page - Applications are valid for 1 year from the day they are received at RIDOH. If you are not licensed within the year you must submit a new application.
- Check or money order (preferred), made payable (in U.S. funds only) to the RI General Treasurer in the amount of **\$65.00** and attached to the upper left-hand corner of the first (Top) page of the application. THIS APPLICATION FEE IS NONREFUNDABLE. Please be advised that this is an application fee and includes the first license **only** up until the next expiration date. All Dental Hygiene licenses expire biennially on June 30th of the even numbered years.
- Valid license as a dental hygienist in the State of Rhode Island.
- Supporting official documentation of a minimum of three (3) years full time work as a Registered Dental Hygienist or completion of at least four thousand five hundred (4500) hours of clinical experience.
- Supporting documentation of completion of a minimum of twelve (12) hours of continuing education in which six (6) hours are hands on experience in a public health setting as defined in the Rules and Regulations Pertaining to Dentists, Dental Hygienists, and Dental Assistants.
- If applying for expedited military status, please complete the Military Expedition Form at the end of this application packet.

### **In addition to above (Out of State Candidates Only)**

- Copy of a valid U.S. Driver's license
- National Board Exam Results be submitted directly to the licensing office.
- ADEX exam results be submitted directly to the licensing office.
- Official Dental Hygiene School Graduate transcript must be submitted directly to this office by the Dental Hygiene School.
- If you have ever been licensed in another state, license verification(s) must be sent directly from the state(s) in which you hold or have held a license. (Interstate Verification Form included in this application can be used for that purpose)

### **Licensure Information**

Please visit the RIDOH website at <http://www.health.ri.gov/licenses> to Verify your license, download Rules and Regulations/Laws for your profession, download change of address forms, other licensing forms or obtain our contact information. HEALTH will not, for any reason, accelerate the processing of one applicant at the expense of others.

### **License Certificates**

RIDOH will be providing wallet license cards ONLY on issuance of licenses. If you wish to receive a license certificate, suitable for framing, please check the box below and attach a separate check in the amount of \$30.00 made payable to RI General Treasurer.

- I would like to receive a license certificate. I have enclosed a separate check in the amount of \$30.00



**7. Preferred Mailing Address**  
Please check ONE

- Please use my **Home Address** as my preferred mailing address
- Please use my **Business Address** as my preferred mailing address

**8. Practice History**  
Please provide your practice history for the last five (5) years.

Month	Year	Month	Year	Name and Location of Facility: NOTE: You may continue information on a separate sheet of paper.
<input type="text"/>	<input type="text"/>	—	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	—	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	—	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	—	<input type="text"/>	<input type="text"/>
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<input type="text"/>	<input type="text"/>	—	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	—	<input type="text"/>	<input type="text"/>

**9. Qualifying Education**  
Please list the name and information about the school that you attended that qualifies you for your **dental hygiene** license.

Type of School (University, College, etc.)

Name of School

Date Graduated

Month Year

Is school accredited by the American Dental Association (ADA)?  Yes  No

Degree Conferred

**10. Regional or State Board Examination**  
Please indicate the type, name and date of your examination for your Dental Hygiene license.

Regional  State

Name of Examination

Date Completed

Month Year

Passed?  Yes  No

**11. National Board Examination**

Date Completed

Month Year

Passed?  Yes  No

**12. Dental Hygiene Licensure**  
List all states or countries in which you are now, or ever have been licensed to practice dental hygiene, or any other profession.

State/Country: _____	<input type="checkbox"/> Active	<input type="checkbox"/> Inactive	State/Country: _____	<input type="checkbox"/> Active	<input type="checkbox"/> Inactive
_____	<input type="checkbox"/> Active	<input type="checkbox"/> Inactive	_____	<input type="checkbox"/> Active	<input type="checkbox"/> Inactive
_____	<input type="checkbox"/> Active	<input type="checkbox"/> Inactive	_____	<input type="checkbox"/> Active	<input type="checkbox"/> Inactive
_____	<input type="checkbox"/> Active	<input type="checkbox"/> Inactive	_____	<input type="checkbox"/> Active	<input type="checkbox"/> Inactive

**13. Board Discipline**

List any disciplinary actions by licensing boards in other states. Please describe any prior or pending Board action or investigation. Please attach any relevant supplemental materials. If necessary, you may continue on a separate 8 1/2 X 11 sheet of paper.

Check here if not applicable.

Licensing Board (abbreviate) and Nature of Action (e.g. TX - Professional Misconduct):

Type of Discipline:

	Month	Year	
_____	<input type="text"/>	<input type="text"/>	_____
_____	<input type="text"/>	<input type="text"/>	_____
_____	<input type="text"/>	<input type="text"/>	_____
_____	<input type="text"/>	<input type="text"/>	_____
_____	<input type="text"/>	<input type="text"/>	_____
_____	<input type="text"/>	<input type="text"/>	_____
_____	<input type="text"/>	<input type="text"/>	_____

**Please describe any prior or pending Board action or investigation. Please attach any relevant supplemental materials.**

**14. Criminal Convictions**

Respond to the question at the top of the section, then list any criminal conviction(s) in the space provided.

If necessary, you may continue on a separate 8 1/2 X 11 sheet of paper.

Have you ever been convicted of a violation, pled Nolo Contendere, or entered a plea bargain to any federal, state or local statute, regulation, or ordinance or are any formal charges pending; including use of illicit substances or operating a motor vehicle while intoxicated. (Please include any offenses which have been expunged from your record)?

Yes       No

Abbreviation of State and Conviction<sup>1</sup> (e.g. CA - Illegal Possession of a Controlled Substance):

	Month	Year
_____	<input type="text"/>	<input type="text"/>
_____	<input type="text"/>	<input type="text"/>
_____	<input type="text"/>	<input type="text"/>

<sup>1</sup>For purposes of this section, a person shall be deemed to be convicted of a crime if he/she plead guilty or if he/she was found or adjudged guilty by a court of competent jurisdiction or has been convicted of a felony by the entry of Nolo Contendere in any state.

**15. Disciplinary Questions**

Check either Yes or No for each question.

1. Has any Health Professional license, certificate, registration, or permit you hold or have held, been disciplined or are any formal charges pending?       Yes       No

2. Have you ever been denied a license, certificate, registration or permit in any state?       Yes       No

**Note:** If you answer "Yes" to any question, you are **required** to furnish complete details, including date, place, reason and disposition of the matter.

**16. Affidavit of Applicant**

I, \_\_\_\_\_, affirm that the information provided on this application form and the documentation provided to support this application is true, accurate complete, and unaltered. I acknowledge that, pursuant to RIGL 11-18-1, knowingly making a false statement on this application form is punishable as a misdemeanor, and that such an act shall constitute cause for denial, suspension, or revocation of my license/permit to practice as a Public Health Dental Hygienist in the State of Rhode Island.

I affirm that I have entered into or will enter into a Written Collaborative Agreement (WCA), prior to practicing as a Public Health Dental Hygienist in accordance with section 2.9.3 of the **Rules and Regulations Pertaining to Dentists, Dental Hygienists, and Dental Assistants.**

I understand that this is a continuing application and that I have an affirmative duty to inform the Rhode Island Board of Examiners in Dentistry of any change in the answers to these questions after this application and this affidavit is signed.

Signature of Applicant \_\_\_\_\_

Date of Signature (MM/DD/YY) \_\_\_\_\_



Substitute forms are not acceptable. This form may be duplicated as needed.

# Rhode Island Board of Examiners in Dentistry

Room 104, 3 Capitol Hill  
Providence, RI 02908-5097  
(401) 222-2828

## RECIPROCITY RELEASE FORM

I am applying for a license to practice as a Public Health Dental Hygienist in the State of Rhode Island. The Rhode Island Board of Examiners in Dentistry requires that the following form be completed by the jurisdiction in which I am now or was previously licensed. This constitutes your authority to release all information in your files, favorable or otherwise, directly to the Rhode Island Board of Examiners in Dentistry at the above address.

Print/Type Full Name	Signature	Date
Previous Names Used	Social Security Number	Date of Birth
License Number	Date Issued	

### THIS SECTION TO BE COMPLETED BY THE DENTAL BOARD

**Basis for issuing License:**

ADA National Board     
  NERB     
  Other Regional Board     
  State Exam \_\_\_\_\_ (State)

If a combination of exams were taken, please list the specific combination:

<b>License Status:</b> <input type="checkbox"/> Active <input type="checkbox"/> Inactive <input type="checkbox"/> Lapsed	<b>Original Date Issued:</b>	<b>Expiration Date:</b>
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**Questions:**

1. Has this applicant ever been investigated by your Board?  Yes     No
2. Has this applicant incurred any disciplinary proceedings in your state, or is any action pending?  Yes     No
3. Has the applicant's license ever been denied, surrendered, reprimanded, suspended, revoked or placed on probation?  Yes     No
4. Do you know of any information that may discredit this person?  Yes     No

If you answer "Yes" to questions 1-4, please provide a written explanation below, and attach a copy of all supporting documentation (e.g., Board order, complaint, etc.).

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### Certification:

Signature	Date
Type or Print Name	
Title	
Full Name and of Licensing Board including State	



Please Affix Board Seal Here

*Please return directly to the Board at the above address. Thank you for your prompt cooperation.*



## Rhode Island Department of Health Military Expedition Form

Please attach this form to the *front* of your completed application and mail to the address shown on the application cover.

Pursuant to Rhode Island General Laws § [5-88-1](#) et seq., upon application, this state may recognize occupational licenses, certificates or permits obtained from other states for military members and their spouses who relocate to this state pursuant to military orders. The Rhode Island Department of Health (RIDOH) will expedite your or your spouse's health professional license application provided the following conditions are met.

### I. PROFESSION/LICENSE TYPE

Please indicate the profession and/or license type you are applying for so that your application can be routed to the correct office:

Profession/License Type: \_\_\_\_\_

### II. MILITARY STATUS

Please check ONE of the following criteria for expedition:

I am in active military duty or a reservist.

I am the spouse of someone in active military duty or the spouse of a reservist.

I am a military veteran with honorable discharge. *You do not need to complete the rest of this application – please skip to the signature line.*

### III. PROOF OF MILITARY STATUS

Please attach a copy of proof of your military status such as one of the following: Leave Earning Statement (LES), Letter from Command, or Copy of Orders

### IV. MILITARY CHANGE OF STATION ORDER

Permanent Change of Station Order

### V. PROOF OF GOOD STANDING

Proof of good standing from the board in the other state in which the person has a license.

### VI. Criminal Background Check (a "BCI") (*unless required in the initial license application*)

BCI completed from the RI Attorney General's Office.

### VII. ATTESTATIONS:

Check all that apply:

No board in any other state has revoked the license for which I am applying as a result of negligence or intentional misconduct.

I have never surrendered an occupational license, certificate, or permit because of negligence or intentional misconduct.

I do not have a complaint, allegation, or investigation currently pending before a board in another state which relates to unprofessional conduct or an alleged crime.

I attest that the above responses and information are true and accurate to the best of my knowledge and that none of the information set forth above is false, erroneous, or defective in any important, as set forth in R.I. Gen. Laws § 11-18-1. I understand that this application is being made to the Rhode Island Department of Health, which shall rely upon my attestation and the information provided in this document.

Signature of Applicant

Date

*On a case-by-case basis RIDOH may grant a temporary license should the military member or spouse need additional time to complete education, training, and/or experience for the licensure in Rhode Island. RIDOH will contact the applicant directly should that be needed.*