



APPLICATION to practice DENTAL HYGIENE through LICENSURE BY CREDENTIAL

ALL FEES ARE NON-REFUNDABLE

Fee: \$200.00

\$100.00 Application Fee
 \$100.00 License Issuance Fee

Payable to "DHBC"

LAW & ETHICS EXAM FEE PAYABLE TO PSI AT A LATER DATE

PAYMENT FORMS ACCEPTED

PERSONAL CHECK
 CASHIERS CHECK
 BUSINESS CHECK
 MONEY ORDER

File #	Amt: \$	Receipt #
RDH Sch: _____ GRAD DATE: _____ NB DATE: _____		
State/Regional Exam: _____ Military <input type="checkbox"/> Photo <input type="checkbox"/> CE <input type="checkbox"/>		
STC <input type="checkbox"/> LA <input type="checkbox"/> NO <input type="checkbox"/> Xray <input type="checkbox"/> Clearances: DOJ <input type="checkbox"/> FBI <input type="checkbox"/>		
Out of State Licenses: _____		

PLEASE TYPE OR PRINT CLEARLY, IF YOU MAKE A MISTAKE, LIGHTLY CROSS IT OUT, DO NOT USE WHITE-OUT. WRITE "N/A" OR A "IF NOT APPLICABLE."

1. APPLICANT'S FULL LEGAL NAME: Last First Middle			2. SOCIAL SECURITY #
List any other names or aliases you have ever used:			3. BIRTH DATE (MM/DD/YY)
4. ADDRESS OF RECORD*		City	State Zip Code
5. EMAIL ADDRESS:		6. TELEPHONE NUMBERS: () Home () Work	
*ONCE LICENSED, THE ADDRESS OF RECORD WILL BE POSTED ON THE INTERNET AND DISCLOSED TO THE PUBLIC UPON REQUEST.			
7. DO YOU HAVE A CERTIFIED DISABILITY OR CONDITION THAT REQUIRES SPECIAL ACCOMMODATIONS FOR TESTING?			YES <input type="checkbox"/> NO <input type="checkbox"/>
If YES, contact the DHBC for a "Special Accommodations" packet.			
8. DENTAL HYGIENE PROGRAM/SCHOOL GRADUATION REQUIREMENT. PROVIDE THE NAME OF AND DATE ON WHICH YOU GRADUATED FROM A DENTAL HYGIENE SCHOOL ACCREDITED BY THE COMMISSION ON DENTAL ACCREDITATION (CODA). SCHOOL NAME: _____ GRAD DATE: / /			
9. LICENSURE IN OTHER STATES REQUIREMENT. LIST ALL THE STATES AND COUNTRIES IN WHICH YOU ARE NOW OR HAVE EVER BEEN LICENSED IN. THIS INCLUDES LICENSURE AS AN RDA OR RDAEF THROUGH THE DENTAL BOARD OF CALIFORNIA.			
STATE	LICENSE TYPE AND NUMBER	DATE LICENSE ISSUED	EXPIRATION DATE
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EXAMINATION REQUIREMENTS

10. WESTERN REGIONAL EXAMINING BOARD (WREB) OR CENTRAL REGIONAL TESTING SERVICES (CRDTS).

WITHIN THE LAST FIVE (5) YEARS,

HAVE YOU TAKEN THE WREB DENTAL HYGIENIST CLINICAL EXAMINATION?

YES NO

If **YES**, disclose the date that you last took the exam. **TEST DATE:** / / WREB or CRDTS

If **YES**, provide the ORIGINAL examination results along with the "Dental Hygiene Summary Profile Sheet" from WREB or CRDTS.

Pursuant to B&P code §1917.1(8)

11. PASSAGE OF A CLINICAL EXAM. YOU MUST PROVIDE PROOF AND THE DATE ON WHICH YOU PASSED A CLINICAL EXAM. *If the proof of passing said clinical exam is included on a license certification from a state licensing board, please indicate which state below.*

CLINICAL EXAM: _____
(i.e. Regional or State)

DATE: / /

Pursuant to B&P code §1917.1(7)

12. PASSAGE OF DENTAL HYGIENE NATIONAL BOARD. PROVIDE AN ORIGINAL NATIONAL BOARD "SCORE REPORT" AND THE DATE ON WHICH YOU SUCCESSFULLY PASSED THE DENTAL HYGIENE NATIONAL BOARD.

DATE: / /

Pursuant to B&P code §1917.1(7)

13. COMPLETION OF APPROVED SPECIFIED COURSEWORK.

YOU MUST PROVIDE PROOF OF PASSING CALIFORNIA DENTAL HYGIENE BOARD-APPROVED COURSEWORK IN:

⇒ **SOFT TISSUE CURETTAGE** ⇒ **ADMINISTRATION OF NITROUS OXIDE/OXYGEN** ⇒ **ADMINISTRATION OF LOCAL ANESTHESIA**

BOARD APPROVED COURSEWORK COMPLETED AT:

_____ ; ON **DATE:** / /

NAME OF CALIFORNIA BOARD-APPROVED PROVIDER

Pursuant to B&P code §1917(f)

14. COMPLETION OF AN ADA APPROVED RADIATION SAFETY COURSE. YOU MUST PROVIDE CERTIFICATION OF ACCEPTABLE RADIATION SAFETY INSTRUCTION ON THE FORM PROVIDED BY THE DHBC OR YOU WILL NOT BE ALLOWED TO EXPOSE DENTAL RADIOGRAPHS.

IF YOU GRADUATED PRIOR TO 1985, YOU MUST TAKE A CALIFORNIA BOARD-APPROVED COURSE IN RADIATION SAFETY.

15. CONTINUING EDUCATION REQUIREMENT. YOU MUST PROVIDE ORIGINAL CERTIFICATES OF COMPLETION OF 25 UNITS OF CONTINUING EDUCATION TAKEN NO MORE THAN TWO (2) YEARS PRIOR TO THE DATE (MONTH/YEAR) OF SUBMITTING THIS APPLICATION.

The following continuing education is mandatory and **must** be taken from a California Board-approved provider:

- Basic Life Support for Healthcare Providers (CPR) by AHA or ARC;
- 2 hour course on the California Dental Practice Act;
- 2 hour California Infection Control.

OF UNITS
COMPLETED

Pursuant to B&P code §1917.1(9)

EXPERIENCE REQUIREMENT

16. **(A) CLINICAL PRACTICE EXPERIENCE.** I CERTIFY THAT I HAVE BEEN IN CLINICAL PRACTICE AS A DENTAL HYGIENIST FOR A MINIMUM OF 750 HOURS PER YEAR, FOR AT LEAST FIVE (5) YEARS IMMEDIATELY PRECEDING THE DATE (MONTH/YEAR) OF SUBMITTING THIS APPLICATION, AND HAVE ATTACHED A COMPLETED "CERTIFICATION OF DENTAL HYGIENE CLINICAL PRACTICE" FORM. YES NO

NOTE: LESS THAN 5 YEARS IS REQUIRED IF IN COMBINATION WITH 17(B) OR 17(C) BELOW.

16. **(B) FULL-TIME FACULTY EXPERIENCE.** I CERTIFY THAT I HAVE BEEN A FULL-TIME FACULTY MEMBER IN AN ACCREDITED DENTAL HYGIENE EDUCATIONAL PROGRAM FOR A MINIMUM OF 750 HOURS PER YEAR, FOR AT LEAST FIVE (5) YEARS IMMEDIATELY PRECEDING THE DATE OF THIS APPLICATION. YES NO

NOTE: LESS THAN 5 YEARS IS REQUIRED IF IN COMBINATION WITH 17(A) ABOVE.
A copy of each pertinent employment contract showing the number of hours performed per year must be submitted with the application.

16. **(C) PENDING CONTRACT TO PRACTICE IN A CLINIC.** I CERTIFY THAT I HAVE BEEN IN CLINICAL PRACTICE AS A DENTAL HYGIENIST (SEE 17A ABOVE) FOR A MINIMUM OF 750 HOURS PER YEAR, FOR AT LEAST THREE (3) YEARS IMMEDIATELY PRECEDING THE DATE OF THIS APPLICATION, AND HAVE ATTACHED THE REQUIRED COMPLETED "CERTIFICATION OF DENTAL HYGIENE CLINICAL PRACTICE" FORM. I FURTHER CERTIFY THAT IN LIEU OF THE REMAINING TWO (2) YEARS OF THE FIVE (5) YEAR CLINICAL PRACTICE EXPERIENCE REQUIREMENT, I HAVE COMMITTED TO PRACTICE IN CERTAIN SETTINGS OR LOCATIONS IN CALIFORNIA. YES NO

Proof of the pending contract to practice in such settings or locations must be provided.

APPLICANT DISCLOSURES

17. **MILITARY SPOUSE DISCLOSURE.** ARE YOU MARRIED TO, OR IN A DOMESTIC PARTNERSHIP OR OTHER LEGAL UNION WITH, AN ACTIVE DUTY MEMBER OF THE ARMED FORCES OF THE UNITED STATES WHO IS ASSIGNED TO A DUTY STATION IN CALIFORNIA UNDER OFFICIAL "ACTIVE DUTY" MILITARY ORDERS? YES NO

If the answer is "YES", you **MUST** provide the following documentations:

- Proof of "Active Duty Orders" of the member.
- Proof of marriage, domestic partnership or legal union.
- Proof of current "Registered Dental Hygienist" license in another State, District or territory of the United States.

Pursuant to B&P code §115.5

18. **DENIAL OF A LICENSE.** HAVE YOU EVER BEEN DENIED A LICENSE, OR PERMISSION TO PRACTICE DENTAL HYGIENE OR PERMISSION TO TAKE ANY EXAMINATION IN ANY STATE, REGION OR COUNTRY? YES NO

If YES, please provide details on page 5 under Section 21, or on a separate attachment.

19. **LICENSE DISCIPLINE.** HAVE YOU EVER BEEN CHARGED WITH, OR BEEN FOUND TO HAVE COMMITTED, UNPROFESSIONAL CONDUCT, INCOMPETENCE, GROSS NEGLIGENCE, OR REPEATED NEGLIGENT ACTS OR MALPRACTICE BY ANY LICENSING BOARD, GOVERNMENT AGENCY OR OTHER DISCIPLINARY BODY? YES NO

"Discipline" includes, but is not limited to, suspension, revocation, probation, or any other restriction. "License" includes permits, registrations and certificates. Check the box next to "**NO**" if you have never had a license disciplined by a government agency or other disciplinary body.

If YES, please provide details on page 5 under Section 21, or on a separate attachment.

19. **(A)** IN LIEU OF FORMAL DISCIPLINE OR WITH CHARGES PENDING, HAVE YOU EVER VOLUNTARILY SURRENDERED A LICENSE TO PRACTICE ANY PROFESSIONAL LEVEL OF DENTISTRY, INCLUDING BUT NOT LIMITED TO HYGIENE OR ASSISTING, IN ANY STATE, REGION, COUNTRY, OR U.S. FEDERAL JURISDICTION? YES NO

If YES, please provide details on page 5 under Section 21 or on a separate attachment.

EXECUTION OF APPLICATION

I, _____ declare that I am the applicant for licensure referred to in this application for licensure in Dental Hygiene through Licensure by Credential (LBC). I have carefully read the questions in the foregoing application and have answered them truthfully, fully and completely.

I certify under penalty of perjury under the laws of the State of California that the information provided in the foregoing and any attachments hereto in this application being submitted to the Dental Hygiene Board of California is true and correct to the best of my knowledge and belief.

20. **SIGNED**

DATE

APPLICANT PHOTOGRAPH

PLEASE PROVIDE A RECENT PHOTOGRAPH.

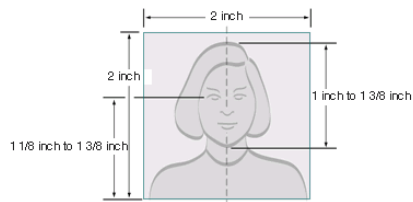
THE PHOTOGRAPH SHOULD BE:

- STANDARD PASSPORT PHOTO
- 2 INCH X 2 INCH SIZE
- SHOULDERS FACING FRONT
- FULL NAME ON THE BACK
- FACE UN-OBSCURED

USE THE DIAGRAM TO THE RIGHT AS A GUIDE.

DATE PHOTO TAKEN: _____

Paper Photo Head Size Template



PLACE
PHOTO
HERE

NOTICE

Effective July 1, 2012, the State Board of Equalization and the Franchise Tax Board may share taxpayer Information with the Board. You are obligated to pay your state tax obligation and your license may be suspended if the state tax obligation is not paid.

