South Dakota State Board of Dentistry
P.O. Box 1079, 1351 N. Harrison Ave. Pierre, SD 57501-1079
Ph: 605-224-1282 Fax: 1-888-425-3032
E-mail: contactus@sdboardofdentistry.com www.sdboardofdentistry.com

COLLABORATIVE SUPERVISION APPLICATION

Submit the following:

1. Completed application;
2. Fee of $20;
3. Completed collaborative agreement; and
4. Letter(s) from employer(s) that verify the following:
    1. A minimum of three years of clinical experience;
    2. A minimum of 4,000 practice hours; and
    3. Completion of at least 2,000 of the required 4,000 practice hours within three years preceding this application.

Name: ________________________ E-mail: ________________________

Address: ________________________ Phone: ________________________

City: ________________________ State: ____________ Zip: __________

Employer Office: ________________________ Phone: ________________________

Physical Address: ________________________ Mailing address: ________________________

City: ________________________ State: ____________ Zip: __________

I am currently licensed as a dental hygienist in South Dakota with license # ___________

Have you ever had disciplinary action taken against your license in any state for any reason? ___Yes ___ No

If yes, please explain ____

____

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I declare and affirm under the penalties of perjury that this application has been examined by me and to the best of my knowledge and belief is in all things true and correct.

Signature: ________________________ Date: ________________________

Printed Name: ____

For Office Use Only: Check # _______________Amount _______________ Date __________

Revised: 06.13.14

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Verification of Employment for Collaborative Supervision Application

To obtain a collaborative supervision registration, a dental hygienist must provide verification of:

- Completion of a minimum of three years of clinical practice in dental hygiene;
- Completion of a minimum of 4,000 dental hygiene clinical practice hours; and
- Completion of at least 2,000 dental hygiene clinical practice hours within three years preceding this application

Name of Applicant: ____

This section is to be completed by an authorized representative of **employer** (*please check/complete all that apply*):

______ I certify that the above-named applicant (was/is) employed by the Employer listed below as a dental hygienist from ______________ to ______________.
Month/Day/Year Month/Day/Year

______ I certify that the above-named applicant completed ________ dental hygiene clinical practice hours during the time he/she was employed as a dental hygienist.

______ I certify that the above-named applicant completed at least 2,000 dental hygiene clinical practice hours within 3 years preceding this application.

I, the undersigned, declare and affirm that according to our records and to the best of my knowledge and belief, the information provided above is true and correct.

____________________________________ ____________________

Signature of Authorized Representative of Employer Date

Name of Authorized Representative: ____

Telephone: ______________________ Email: __________________________

Name of Employer: ____

Address of Employer: ____