



South Dakota State Board of Dentistry

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APPLICATION FOR DENTAL HYGIENE LICENSE BY CREDENTIAL VERIFICATION

This application is for individuals that are currently licensed in another state that have completed a minimum of three thousand dental hygiene clinical practice hours within the five years immediately preceding the date of application. Please be sure to submit all required information and fees with this application. Applications will be closed if all required information is not received within twelve months.

If you are an active duty member of the armed forces of the United States or the spouse of an active duty member of the armed forces of the United States who is the subject to a military transfer to South Dakota and hold a license or registration in good standing to practice as a Dental Hygienist in another state, please contact our office for an Active Duty Military Personnel or Spouse License or Registration Application.

Links to the statutes and administrative rules that govern the profession, often referred to as the Dental Practice Act, are available on our website. The Jurisprudence Exam questions are taken directly from the Dental Practice Act. Once our office receives your application and the required Jurisprudence Examination fee, you will be emailed a link to take the examination. Please be sure the email listed on this application is correct. This exam must be completed by the applicant. *This is an open book examination intended to acquaint the applicant with the statutes and administrative rules related to the practice of dentistry. This examination is not timed. An applicant is able to start the exam, save it, and complete it at a later time.*

Applications will be reviewed at the next scheduled board meeting if all materials, including all required documents and the results of the Jurisprudence Exam, are received 30 days prior to that meeting. If requested, an applicant must appear for a personal interview with the Board. Board meeting dates and times are listed on the Board's website.

A dental hygienist must obtain a permit from the Board to administer nitrous oxide or local anesthesia, or to monitor patients under general anesthesia and deep sedation or moderate sedation. Applications are available on the Board's website.

The Board of Dentistry will carefully review each application for licensure. If the applicant has an unresolved disciplinary complaint pending before a dental board, a license will not be issued. Please note that intentional failure to provide complete information or concealment of relevant information needed by the Board for a thorough review of credentials may result in denial of an application or may be considered as the basis for discipline, including but not limited to revocation of any license which may have been issued. The Board may require a laboratory or clinical examination if it has reason to believe an applicant cannot practice safely.

After reviewing this application and the corresponding checklist, please contact our office if you have any questions.

DENTAL HYGIENE LICENSE BY CREDENTIAL VERIFICATION
APPLICATION CHECKLIST:

The following must be submitted before your application will be processed:

1. A statement from a healthcare provider (MD, DO, CNP, or PA) attesting to the applicant's physical and mental condition. *Only the form provided in this application will be accepted.*
2. A copy of the applicant's National Board Dental Hygiene Examination score. *The examination results must be sent directly to our office from the Joint Commission on National Dental Examinations.*
3. A copy of the applicant's patient based clinical competency examination results. *The examination results must be sent directly to our office from the testing agency or must be accessible online.*
4. A certified letter verifying the license number and status of the applicant's license from the board of dentistry in each state in which the applicant is or has been licensed. *The applicant must request a verification letter from each state in which the applicant is or has been licensed and each letter must be certified and sent directly to our office from the respective board of dentistry.*
5. Certified transcripts from an American Dental Association Commission on Dental Accreditation accredited United States dental hygiene school. *The transcripts must be sent directly to our office from the school and contain verification of ADA CODA status at time of graduation.*
6. A copy of the applicant's birth certificate.
7. If applicable, documentation of any name change (i.e. marriage license).
8. A copy of the applicant's current cardiopulmonary resuscitation (CPR) card. *South Dakota requires the American Heart Association for the Basic Life Support Provider (BLS), the American Red Cross for the Professional Rescuer or the American Red Cross for Basic Life Support (BLS).*
9. A completed South Dakota Jurisprudence Examination. *Once the application is received, the applicant will be emailed a link to the Jurisprudence Examination, along with links to the statutes and administrative rules covered by the examination.*
10. A \$200.00 dental hygiene license application fee along with a \$115.00 Jurisprudence Examination fee made payable to the "South Dakota State Board of Dentistry."
11. If applicable, a \$50.00 temporary registration application fee.
12. If applicable, your application(s) to administer local anesthesia, administer nitrous oxide inhalation analgesia or monitor patients under anesthesia, along with the appropriate fee(s).

**SOUTH DAKOTA STATE BOARD OF DENTISTRY
APPLICATION FOR DENTAL HYGIENE LICENSE BY
CREDENTIAL VERIFICATION**

You must answer every question on this application or your application will be returned.
If additional space is needed, please attach additional sheets as necessary.

Name (First, Middle, Last): _____

Home Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Social Security Number: _____

Email: _____

This email will be used to correspond with you regarding your application. Please be sure the email is current.

Office you intend to practice at in South Dakota: _____

Office Address: _____ Office Phone: _____

City: _____ State: _____ Zip: _____

Dental Hygiene School:

Date of Dental Hygiene Diploma: _____

Name of School: _____

City: _____ State: _____ Zip: _____

Transcripts and verification of ADA CODA status at time of graduation have been requested. Yes No

Regional Examination:

I passed the following patient based clinical competency examination:

- CRDTS
- WREB
- SRTA
- CITA
- CDCA (formerly NERB)

Please Select One:

Documentation of passage of the above referenced patient based clinical competency examination has been requested and is being sent directly to the Board office from the entity that administered the examination, or

Documentation of passage of the above referenced patient based clinical competency examination can be accessed online through the entity that administered the examination.

Dental Hygiene Active Practice:

Yes No. Do you currently hold a valid license issued by a different state or the District of Columbia to practice as a dental hygienist?

Yes No. I hereby certify that I have completed more than 3,000 dental hygiene clinical practice hours during the five years preceding this application while licensed in a state. *If requested, you will be required to provide verification from your employer(s).*

Please submit the following information for each state in which you are or have been licensed. *You must also submit a certified letter verifying the license number and status of your license from the board of dentistry in each state in which you are or have been licensed. **These letters must be sent directly to our office.***

| | | | |
|-------|-----------|---------------|--------|
| STATE | LICENSE # | DATE RECEIVED | STATUS |
| STATE | LICENSE # | DATE RECEIVED | STATUS |
| STATE | LICENSE # | DATE RECEIVED | STATUS |
| STATE | LICENSE # | DATE RECEIVED | STATUS |

Employment History – Dental Hygienist: Please list in chronological order.

Employer Name: _____
Current Address: _____
Current Telephone Number: _____
Position Held: _____
Reason for Termination/Resignation: _____
Dates Employed – From: _____ To: _____ Active Practice - Total Dental Hygiene
Clinical Practice Hours Provided For this Employer ***During the Last Five Years:*** _____

Employer Name: _____
Current Address: _____
Current Telephone Number: _____
Position Held: _____
Reason for Termination/Resignation: _____
Dates Employed – From: _____ To: _____ Active Practice - Total Dental Hygiene
Clinical Practice Hours Provided For this Employer ***During the Last Five Years:*** _____

Employer Name: _____
Current Address: _____
Current Telephone Number: _____
Position Held: _____
Reason for Termination/Resignation: _____
Dates Employed – From: _____ To: _____ Active Practice - Total Dental Hygiene
Clinical Practice Hours Provided For this Employer ***During the Last Five Years:*** _____

Employer Name: _____
Current Address: _____
Current Telephone Number: _____
Position Held: _____
Reason for Termination/Resignation: _____
Dates Employed – From: _____ To: _____ Active Practice - Total Dental Hygiene
Clinical Practice Hours Provided For this Employer *During the Last Five Years*: _____

Employer Name: _____
Current Address: _____
Current Telephone Number: _____
Position Held: _____
Reason for Termination/Resignation: _____
Dates Employed – From: _____ To: _____ Active Practice - Total Dental Hygiene
Clinical Practice Hours Provided For this Employer *During the Last Five Years*: _____

Employer Name: _____
Current Address: _____
Current Telephone Number: _____
Position Held: _____
Reason for Termination/Resignation: _____
Dates Employed – From: _____ To: _____ Active Practice - Total Dental Hygiene
Clinical Practice Hours Provided For this Employer *During the Last Five Years*: _____

Other Licenses:

Have you ever held a license other than a license to practice as a dental hygienist? Yes No

Please submit the following information for each state in which you have held a license other than a license to practice as a dental hygienist.

STATE _____ LICENSE # _____ DATE RECEIVED _____ STATUS _____
STATE _____ LICENSE # _____ DATE RECEIVED _____ STATUS _____

Military Service:

Are you an active duty member or the spouse of an active duty member of the armed forces of the United States? Yes No

If yes, were you or your spouse the subject of a military transfer to South Dakota?
Yes No N/A

Temporary Registration:

Yes No. I am requesting a temporary registration and a fee of \$50 has been included with this application.

| | |
|---|-----------------------|
| 1. Have you ever been convicted, pled no contest/nolo contendere, pled guilty to, or been granted a deferred judgment or suspended imposition of sentence or had prosecution deferred with respect to a felony? | (Check one) Yes No |
| 2. Have you ever been convicted, pled no contest/nolo contendere, pled guilty to, or been granted a deferred judgment or suspended imposition of sentence, or had prosecution deferred with respect to a misdemeanor other than a class 2 misdemeanor traffic offense? *It is the applicant's responsibility to confirm whether the infraction is a class 1 or class 2 misdemeanor. | Yes No |
| 3. Is there any pending criminal prosecution against you? | Yes No |
| 4. Are you currently being investigated or is disciplinary action pending against any professional license(s) or certificate(s) held by you? | Yes No |
| 5. Has any license, registration, permit or certificate held by you in any state or country been denied, revoked, suspended, stipulated, or have you been placed on probation or otherwise subjected to any type of disciplinary action? | Yes No |
| 6. Have you ever been denied a license to practice in another state? | Yes No |
| 7. Have you ever appeared or been requested to appear before any licensing board concerning any violation of law or regulation of any state district, territory or province of the United States or Canada? | Yes No |
| 8. Have you ever had privileges revoked, reduced, or otherwise restricted at any hospital or other healthcare provider entity? | Yes No |
| 9. Have you ever been subject to proceedings by a professional society to revoke, reduce or restrict membership? | Yes No |
| 10. Have you ever been subject to a negligence or malpractice judgment or settlement during the scope and course of your practice? | Yes No |
| 11. In the five years prior to application, have you engaged in the illegal use of drugs? | Yes No |
| 12. Are you currently engaged in the illegal use of drugs? | Yes No |
| 13. In the five years prior to application, has your use of alcohol adversely affected your practice of the profession? | Yes No |
| 14. Does your use of alcohol adversely affect your ability to practice currently? | Yes No |
| 15. In the five years prior to application, have you completed a supervised rehabilitation program for drugs or alcohol? | Yes No |
| 16. Are you currently participating in a supervised rehabilitation program for drugs or alcohol? | Yes No |
| 17. Have you experienced a physical, emotional, or mental condition that has adversely affected your practice or endangered the health or safety of your patients in the five years prior to application? | Yes No |

| | |
|--|--------|
| 18. Do you currently owe child support arrearages in the amount of \$1,000 or more? | Yes No |
| 19. Have you had adverse action or ethical violation(s) during any education, residency or training program? | Yes No |
| 20. Have you ever been released from the military by any means other than an honorable discharge? | Yes No |
| 21. Are you in any way using fraud or deception in applying for a license to practice in South Dakota? | Yes No |
| <i>For questions 1-21 on above, please provide a detailed explanation for each YES response in the space provided at the end of this application. You must also submit copies of all communications (to and from) the citing agency or board, including evidence of completion/compliance with requirements.</i> | |

I, _____, the applicant, being first duly sworn, certify that I am the person referred to in this application, that under penalty of perjury all the information contained in this application and in any attachments or additional documents submitted herewith is true and correct and that all persons and organizations whether public or private, are authorized to release to the South Dakota State Board of Dentistry all information, files or records requested in connection with this application.

Applicant Signature: _____ Date: _____

Subscribed and sworn before me this _____ day of _____ 20_____

My commission expires _____

Notary Public

Attach Photo Here
For identification purposes,
the applicant shall furnish one
passport size photograph
taken not more than six
months before the date of
application.

CERTIFICATE OF MORAL CHARACTER:

This certifies that I have personally known _____
for _____ years and that I believe him or her to be of good moral character and that I am not
related to him or her by kinship or marriage.

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Signature: _____ Date: _____

This certifies that I have personally known _____
for _____ years and that I believe him or her to be of good moral character and that I am not
related to him or her by kinship or marriage.

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Signature: _____ Date: _____

Authorization and Release

I, _____, having filed an application for a license to practice as a dental hygienist in the state of South Dakota, hereby apply for verification of my credentials and consent to have an investigation made as to my moral character, professional reputation and fitness for the practice of dentistry. I agree to give any further information which may be required in reference to my past record. I understand that I will not receive and am not entitled to a copy of the investigative report or to know its contents and I further understand that the content of the report is privileged and confidential. I understand that I will be afforded a reasonable opportunity to rebut or explain any adverse information disclosed by the investigation.

I also authorize and request every person, firm, company, corporation, governmental agency, court, association or institution having control of any documents, records, and other information, or pertinent data to permit the South Dakota State Board of Dentistry or any of its agents or representatives to inspect and make copies of such documents, records, and other information.

I hereby release, discharge, and hold harmless the South Dakota State Board of Dentistry, its agents and representatives, and any other person so furnishing information from any and all liability of every nature and kind arising out of the furnishing or inspection of such documents, records and other information.

I understand that the South Dakota State Board of Dentistry cannot accept any altered Authorization and Release forms.

I have read the foregoing document and have answered all questions fully and completely. 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. I understand that falsification or omission of information, including intentional failure to provide complete information or concealment of relevant information needed by the Board for a thorough review of credentials, may result in denial of my application or may be considered as the basis for discipline or revocation of any license which may have been issued.

Signature: _____ Date: _____

For Office Use Only: Check# _____ Amount _____ Date _____



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To Whom It May Concern:

The South Dakota State Board of Dentistry is conducting a review of the professional credentials of an applicant for a license to practice as a dentist or dental hygienist in the State of South Dakota. One of the requirements for licensure is a statement by a licensed MD, DO, PA or CNP that the applicant has been examined and found physically and mentally acceptable to safely practice as a dentist or dental hygienist.

Please examine the applicant, at his or her own expense, and provide your professional assessment of the applicant's fitness to practice as a dentist or dental hygienist by completing the form below.

Medical Evaluation of License Applicant

Applicant's Name: _____

Date of Medical Evaluation: _____

Please place a check mark in the box next to the statement that applies.

I have examined the above named applicant and find no medical or mental condition, which precludes the ability to safely practice as a dentist or a dental hygienist. My examination reveals that the applicant is not chemically dependent, nor do I find that the applicant has any physical or mental disabilities.

I have examined the above named applicant and have found conditions which may have an impact on this person's ability to safely render health care to patients as a dentist or dental hygienist. Please see the attached document outlining the conditions that were found.

Name of Office

Address

City, State, Zip

(_____) _____
Office Phone Number

Name

License #

State

I am licensed as a (circle one): MD

DO

PA

CNP

Signature

Date

For questions 1-21 on pages 6 & 7, please provide a detailed explanation for each YES response in the space provided below. You must include a complete description of dates and events. If you have more than one violation to report, you must list the violations in chronological order (most recent first). If you need additional space, please attach additional sheets as necessary.

You must also submit copies of all communications (to and from) the citing agency or board, including evidence of completion/compliance with requirements. You must group the documents by violation and put them in chronological order (most recent first).