

# 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.org

# 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. Once your application and fees are received in our office, and an initial review is completed, you will receive a confirmation email with information related to your specific 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 of 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.

# <u>DENTAL HYGIENE LICENSE BY CREDENTIAL VERIFICATION</u> <u>APPLICATION CHECKLIST:</u>

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 or must be accessible online.
- 3. A copy of the applicant's patient based or equivalent manikin 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. Verification of the license number and status of your license from the board of dentistry in each state in which you are or have been licensed. The applicant must request a verification letter from each state in which the applicant is or has been licensed if that state does not provide online verification. 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. Electronic transcripts are accepted.*
- 6. A copy of the applicant's birth certificate or equivalent documentation.
- 7. If applicable, documentation of any name change (i.e. marriage license).
- 8. A copy of the applicant's current cardiopulmonary resuscitation (CPR) card. An approved CPR course is a course intended for a Healthcare Provider that meets the required knowledge and objectives outlined in the American Heart Association guidelines for BLS or American Heart Association Guidelines for CPR and ECC, and includes a hands-on skills assessment.
- 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 \$300.00 dental hygiene license application fee along with a \$135.00 Jurisprudence Examination fee made payable to the South Dakota State Board of Dentistry.
- 11. If applicable, a \$100.00 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, Mi    | ddle, Last):                        |                             |   |
|--------------------|-------------------------------------|-----------------------------|---|
| Home Address:      |                                     |                             |   |
| City:              |                                     | State:                      | Zip:                                    |
| Phone:             | Date of Birth:                      | Social Security             | Number:                                 |
| Email:             |                                     |                             | . Please be sure the email is current.  |
| This email v       | vill be used to correspond with you | regarding your application. | Please be sure the email is current.    |
| If known, office   | you intend to practice at in Sout   | h Dakota:                   |   |
| Office Address:    |                                     | Office Pho                  | one:                                    |
| City:              |                                     | State:                      | Zip:                                    |
| Start date, if kno | own:                                |                             |   |
| with this applic   | eation.                             | ·                           | a fee of \$100 has been included        |
| Name of School     | :                                   |                             |   |
| City:              |                                     | State:                      | Zip:                                    |
| Transcripts and    | verification of ADA CODA statu      | is at time of graduation h  | ave been requested. Yes No              |
| Clinical Exam      | ination:                            |                             |   |
|                    |                                     |                             | clinical competency based clinical ear: |
| Please Select C    | <u>)ne</u> :                        |                             |   |
| Docum              | entation of passage of the abo      | ve referenced clinical c    | competency examination has bee          |

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 clinical competency examination can be accessed online through the entity that administered the examination.

| Dental Hygiene | Active | <b>Practice:</b> |
|----------------|--------|------------------|
|----------------|--------|------------------|

|                     |  | preceding this application.                                     | re than 3,000 dental hygiene clinical If requested, you will be required to       |
|---------------------|--|---|---|
| Yes<br>Columb       | No. Do you curre ia to practice as a denta       | •   | ned by a different state or the District of                                       |
|                     |  | nation for each state in which<br>ach additional sheets as nece | ch you are or have been licensed. If essary.                                      |
| STATE               | LICENSE#   | DATE RECEIVED   | STATUS  |
|                     |  | DATE RECEIVED   |   |
|                     |  | DATE RECEIVED   |   |
|                     |  | DATE RECEIVED   |   |
| board of dent       | istry in each state in v                         |   | er and status of your license from the<br>d if that state does not provide online |
|                     | History – Dental Hyg<br>attach additional sheets |   | logical order. If you need additional   |
| Employer Nar        | me:  |   |   |
| Current Addre       | ess:   |   |   |
| Current Telep       | hone Number:                                     |   |   |
|                     |  |   |   |
| Reason for Te       | ermination/Resignation                           | :   |   |
| <b>Dates Employ</b> | ved – From:                                      | _ (month/year) To:  | _ (month/year)  |
| Total Dental I      | Hygiene Clinical Practi                          | ce Hours For this Employer                                      | During the Last Five Years:   |
| Employer Nar        | me:  |   |   |
| Current Addre       | ess:   |   |   |
|                     |  |   |   |
| Position Held:      | :  |   |   |
| Reason for Te       | ermination/Resignation                           | :   |   |
| <b>Dates Employ</b> | ved – From:                                      | (month/year) To:  | _ (month/year)  |
| Total Dental I      | Hygiene Clinical Practi                          | ce Hours For this Employer                                      | During the Last Five Years:   |
| Employer Nar        | me:  |   |   |
|                     |  |   |   |
| Current Telen       | hone Number:                                     |   |   |
| Position Held:      | •  |   |   |
| Reason for Te       | ermination/Resignation                           | ·   |   |
| Dates Employ        | ved – From:                                      | (month/year) To:  | (month/year)  |
| Total Dental F      | Hygiene Clinical Practi                          | ce Hours For this Employer                                      | During the Last Five Years  |

| Employer Name:   |
|--|
| Current Address:   |
| Current Telephone Number:  |
| Position Held:   |
| Reason for Termination/Resignation:  |
| Dates Employed – From: (month/year) To: (month/year)   |
| Total Dental Hygiene Clinical Practice Hours For this Employer <i>During the Last Five Years</i> :   |
| Employer Neme  |
| Employer Name:   |
| Current Telephone Number:  |
| Position Held:   |
| Reason for Termination/Resignation:  |
| Dates Employed – From: (month/year) To: (month/year)   |
| Total Dental Hygiene Clinical Practice Hours 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.                      |
| STATELICENSE #DATE RECEIVEDSTATUS  |
| STATELICENSE #DATE RECEIVEDSTATUS  |
| 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 $N/A$   |
| CPR:   |
| By initialing below, I hereby attest that the CPR course I am submitting a card for meets all of the following   |
| requirements:  |
| Is a Basic Life Support course intended for a Healthcare Provider; and   |
| Included knowledge and objectives in accordance with the American Heart Association Guidelines for BLS or American Heart Association Guidelines for CPR and ECC; and |
| Included a hands-on skill assessment.  |
|  |

|   | (Check One) |
|---|-------------|
| 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?   | 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      |

**Please note:** If you answered YES to 1 or 2, provide a personal statement detailing the nature of the crime, whether you think the crime relates to your practice, and description of rehabilitation efforts. You must also submit copies of charges or citations and ALL communications (to and from) the citing agency AND the court of jurisdiction, including evidence of completion/compliance with court requirements. You must attach all communications for a violation to the signed and dated explanation of that violation. Please put correspondence in chronological order (most recent first). If you have more than one violation, please do the same for each violation.

This does not include records that have been sealed, expunged, or pardoned.

| _   |   |     |    |
|-----|---|-----|----|
| 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 | N  |
| 8.  | Have you ever had privileges revoked, reduced, or otherwise restricted at any hospital or other healthcare provider entity?   | Yes | N  |
| 9.  | Have you ever been subject to proceedings by a professional society to revoke, reduce or restrict membership?   | Yes | N  |
| 10. | Have you individually, or through your dental entity, been subject to a negligence or malpractice judgment or settlement during the scope and course of your practice?  | Yes | N  |
| 11. | Are you currently engaged in the illegal use of drugs?  | Yes | N  |
| 12. | Does your use of alcohol adversely affect your ability to practice currently?   | Yes | N  |
| 13. | Are you currently participating in a supervised rehabilitation program or case management/monitoring program for a mental health or substance use related issue or disorder?  | Yes | N  |

| 14. Are you currently suffering from any condition for which treated that impairs your ability to practice in a comprofessional manner?  | · ·   | Yes  | No             |
|--|---|--|----------------|
| 15. Do you currently owe child support arrearages in the armore?   | mount of \$1,000 or   | Yes  | No             |
| 16. Have you had adverse action or ethical violation(s) during a residency or training program?  | any education,  | Yes  | No             |
| 17. Have you ever been released from the military by any mea honorable discharge?  | ns other than an  | Yes  | No             |
| 18. Are you in any way using fraud or deception in applying for practice in South Dakota?  | or a license to   | Yes  | No             |
| I,, the applicant, being   | erjury all the informat   | ion conta  | ined           |
| this application and in any attachments or additional documents and that all persons and organizations whether public the South Dakota State Board of Dentistry all information, for the south Dakota State Board of Dentistry all information, for the south Dakota State Board of Dentistry all information, for the south Dakota State Board of Dentistry all information, for the south Dakota State Board of Dentistry all information, for the south Dakota State Board of Dentistry all information in the south Dakota State Boar | or private, are authori   | ized to rel  | lease          |
| this application and in any attachments or additional documents and that all persons and organizations whether publicathe South Dakota State Board of Dentistry all information, figures this application.   | or private, are authori<br>iles or records requeste   | ized to rel<br>ed in com                                 | lease<br>necti |
| this application and in any attachments or additional documents and that all persons and organizations whether public the South Dakota State Board of Dentistry all information, from this application.  Applicant Signature:  | or private, are authori iles or records requeste Date:  | ized to rel  | lease<br>necti |
| this application and in any attachments or additional documents and that all persons and organizations whether public the South Dakota State Board of Dentistry all information, from this application.  Applicant Signature:  | Or private, are authoriciles or records requested  Date:  Attach Photo For identification pur applicant shall furr passport size photogranot more than six more | Here rposes, the nish one raph taken nths before         | lease<br>necti |
| this application and in any attachments or additional documents and that all persons and organizations whether public the South Dakota State Board of Dentistry all information, from this application.  Applicant Signature:  | or private, are authori iles or records requeste  Date:  Attach Photo For identification pur applicant shall furr passport size photogr                         | Here rposes, the nish one raph taken nths before         | lease<br>necti |
| this application and in any attachments or additional documents and that all persons and organizations whether public the South Dakota State Board of Dentistry all information, from this application.  Applicant Signature:  | Or private, are authoriciles or records requested  Date:  Attach Photo For identification pur applicant shall furr passport size photogranot more than six more | Here rposes, the nish one raph taken nths before         | lease<br>necti |
| My commission expires  | Or private, are authoriciles or records requested  Date:  Attach Photo For identification pur applicant shall furr passport size photogranot more than six more | Here rposes, the nish one raph taken nths before         | lease<br>necti |
| this application and in any attachments or additional documents and that all persons and organizations whether public the South Dakota State Board of Dentistry all information, from this application.  Applicant Signature:  Subscribed and sworn to before me this day of  You commission expires  Notary Public  | Date:  Attach Photo For identification pur applicant shall furr passport size photogr not more than six more the date of applic                                 | Here rposes, the nish one raph taken nths before cation. | lease          |

# **CERTIFICATE OF MORAL CHARACTER:**

| This certifies that I  | have personally known                     | f                                       |
|------------------------|---|---|
| years and              | that I believe him or her to be of good m | oral character and that I am not relate |
| to him or her by kinsh | ip or marriage.                           |   |
| Name:                  |   |   |
| Address:               |   |   |
| City:                  | State:                                    | Zip:                                    |
| Phone:                 | Email:                                    |   |
| Signature:             | Dat                                       | e:                                      |
|                        |   |   |
|                        |   |   |
|                        |   |   |
| This certifies that I  | have personally known                     | f                                       |
| years and              | that I believe him or her to be of good m | oral character and that I am not relate |
| to him or her by kinsh | ip or marriage.                           |   |
| Name:                  |   |   |
| Address:               |   |   |
| City:                  | State:                                    | Zip:                                    |
| Phone:                 | Email:                                    |   |
| Signature:             | Dat                                       | e:                                      |

# **Authorization and Release**

| 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 and affirm under the penalties of perjury that this application has been of my knowledge and belief, is in all things true and correct. I underst of information, including intentional failure to provide complete relevant information needed by the Board for a thorough review of cremy application or may be considered as the basis for discipline or revolution been issued.  | examined by me, and to the best<br>tand that falsification or omission<br>information or concealment of<br>redentials, may result in denial of |  |  |
|   |  |  |  |
| Signature: Date:  |  |  |  |
|   |  |  |  |
| Mail completed application and fees to: outh Dakota State Board of Dentistry O Box 1079 ierre, SD 57501  For Office Use Only: Check # Amount Date   |  |  |  |



# 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.org

#### 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

| tatement that applies.  |   |
|---|---|
| or a dental hygienist. My exand that the applicant has any phycant and have found condition | nental condition, which precludes<br>nination reveals that the applicant<br>ysical or mental disabilities.<br>as which may have an impact on<br>or dental hygienist. Please see the                         |
| Address   |   |
| ()<br>Office Phone Number   |   |
| License #   | State   |
| DO PA   | CNP   |
| Date  | _   |
| ָ<br>֝  | cant and find no medical or mor a dental hygienist. My example that the applicant has any physicant and have found conditions the care to patients as a dentist of the state of the care found.  Address  ( |

| For questions 1-18 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).  |
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