North Dakota Board of Dental Examiners

PO Box 7246, Bismarck, ND 58502 • Phone 701-258-8600 • Fax 701-224-9824 Web
www.nddentalboard.org • Email info@nddentalboard.org

APPLICATION FOR DENTAL HYGIENE - LICENSE BY EXAMINATION
NON-REFUNDABLE APPLICATION FEE $220

REQUIREMENTS FOR LICENSURE

☐ **COMPLETED AND NOTORIZED APPLICATION** – **Submit the application and application fee. Once the Board receives the application and application fee, background check information is sent to the applicant.** You may then submit transcripts, test scores, verifications and other documents. To receive notice that your application has been delivered to the board, it is suggested that the application be mailed by "Certified Mail-Return Receipt Requested" or with "Delivery Confirmation". Attach recent signed photo to application.

If you answered YES to questions pertaining to charges, crimes etc; the Board will require copy of evaluation and recommendations for treatment if any were issued; a copy of the criminal charges, reported offense and dates, police report and judgment and disposition of criminal complaint; disposition of the offense, final disposition, any orders or any actions pending. Please send your information directly to the Board as soon as you can. If you answered YES to a question regarding "ever being named as a defendant or respondent in any malpractice proceedings" please send a copy of your resolution documentation such as a default judgment, summary judgment, voluntary dismissal, involuntary dismissal, or settlement.

☐ **LICENSE FEE** – **LICENSE FEES ARE NON-REFUNDABLE -** If the fee is not submitted with the application the application will be returned. The Board will not return other items sent by the applicant such as references, or transcripts. If an applicant fails to complete all of the requirements for licensure within 12 months from the postmarked date the application and fee are no longer valid. Please read laws and rules regarding license requirements carefully, application fees are non-refundable.

☐ **MEMBER OR SPOUSE OF A MEMBER OF THE ARMED FORCES OF THE UNTIED STATES OR A RESERVE COMPONENT OF THE ARMED FORCES OF THE UNITED STATES IN ACCORDANCE WITH MILITARY ORDERS OR STATIONED IN THIS STATE BEFORE A TEMPORARY ASSIGNMENT TO DUTIES OUTSIDE THIS STATE –** Upon request, the Board may issue a provisional license or temporary permit not to exceed two years and remains valid while the active military member or spouse is making progress toward satisfying the unmet licensure requirements. The applicant must demonstrate competency by standards as issued by the Board which must include demonstrating experience in the profession at least two of the four years preceding the date of application. Pursuant to NDCC 43-51-11.1 the Board may require an applicant to submit to a statewide and national criminal history record check. An active military member or spouse issued a temporary permit or provisional license has the same rights and duties as a licensee issued a license under the traditional licensure method.

☐ **CRIMINAL BACKGROUND CHECK** – Applicants are required to submit fingerprints and undergo a criminal background check. The appropriate forms will be sent to you upon receipt of your application and application fee. Return the fingerprint forms which may be completed by local law enforcement or fingerprinting service center which may take digital prints. Submit both fingerprint cards to the NDBDE with your check or money order payable to the ND Attorney General. The process may take up to ten days. Results shall be received by the board prior to the issuance of a license to practice. Check with local law enforcement for scheduling.

☐ **FINGERPRINTS WILL BE USED TO CHECK THE CRIMINAL HISTORY RECORDS OF THE FBI. THE BOARD PROVIDES THE APPLICANT THE OPPORTUNITY TO COMPLETE, OR CHALLENGE THE ACCURACY OF, THE INFORMATION CONTAINED IN THE FBI IDENTIFCATION RECORD. APPLICANTS ARE ADVISED THAT PROCEDURES FOR OBTAINING A CHANGE, CORRECTION, OR UPDATING OF AN FBI IDENTIFICATION RECORD ARE SET FORTH IN TITLE 28, C.F.R., § 16.34. GRANTING OF LICENSURE SHALL NOT BE BASED ON INFORMATION IN THE RECORD UNTIL THE APPLICANT HAS BEEN AFFORDED A REASONABLE TIME TO CORRECT OR COMPLETE THE RECORD, OR HAS DECLINED TO DO SO.**

☐ **DIPLOMA** – Submit an 8" x 11" photocopy.

☐ **OFFICIAL TRANSCRIPT** – Submit a FINAL, OFFICIAL transcript of dental hygiene education. This transcript must be sent to the ND board office by the school and must show the date of graduation, the degree or certification earned, and

have the seal of the school. It is the applicant's responsibility to arrange to have the transcript mailed directly to the board office from the school. (Copies, student transcripts or incomplete transcripts are not acceptable.)

- **NATIONAL BOARD RESULTS** - Provide evidence of successful completion of an examination administered by the Joint Commission on National Dental Examinations taken within two years of application. Contact, 211 E. Chicago Avenue, Ste 600, Chicago, Illinois 60611-2637, telephone (800) 232-1694, or website: **https://www.ada.org/1632.aspx** to request that an OFFICIAL REPORT of your National Board scores be sent directly to the Board office. Copies must be notarized.

- **CLINICAL EXAM RESULT** - Provide evidence of successful completion of a Board approved clinical manikin or live patient examination taken within two years of application. The ND Board accepts any dental hygiene clinical competency exam taken before September 17, 2009; or exams administered by CRDTS, CITA, ADEX or WREB. Copies must be notarized.

- **JURISPRUDENCE EXAMINATION** –All dental hygiene applicants are required to successfully complete the online jurisprudence exam. Once your application is received by the Board, you may take the online jurisprudence exam, and review documents as they are received by the Board. Go to www.nddentalboard.org, Practitioners tab; scroll down to Application Status, enter the information requested. The jurisprudence exam is on that page. The test will shut down after successfully answering a designated number of questions for a passing score. In preparation, see the Laws and Rules tab found on the Board's website.

- **PHYSICAL EXAMINATION** – Submit proof of recent physical on a *Confidential Professional Medical Reference* form provided by the Board. A physical health examination must be within the last 12 months and may be signed by a physician assistant or a nurse practitioner.

- **EYE EXAM -** Submit proof of recent eye examination on a *Confidential Professional Medical Reference* form provided by the Board. Eye examination must within the last 12 months.

- **VERIFICATION OF LICENSURE** – A license verification form from any state in which you previously held a professional license or currently hold a professional license must be submitted to the NDSBDE. Verification must be sent directly to the NDBDE from the state which verifies license or registration attesting that the license was in good standing, or reporting any disciplinary actions. Copies of licenses are not acceptable. A website print out is not acceptable.

- **PROOF OF CONTINUING EDUCATION** – Proof of CE is not required if the application is submitted within 24 months of the completion of the dental hygiene program.

- **LOCAL ANESTHESIA PERMIT APPLICATION** – Applicants intending to utilize the duty of local anesthesia must submit a permit application with the required documentation. A local anesthesia permit is not a requirement for licensure unless you intend to utilize the expanded duty.

- **NAME CHANGE DOCUMENTATION** – Submit the name/address change form and attach a copy of a certified document which indicates the reason for a name change.

- **CPR** – A photocopy of CPR or BLS certification within 24 months of application indicating expiration date. Online life support courses must contain a hands-on component.

Rev.09/20/2021

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Application for Initial Dental Hygiene License

Application Fees are Non-refundable - $220

OFFICE USE ONLY - Postmark Date: _____ Date Received _____ Amount _____ Check # _____

Submit application and application fee. Once an application has been submitted, the applicant will receive information regarding the criminal background check. Please submit supporting documents such as transcripts, test scores, verifications and other items after you submit the application. Please type or print clearly. It is the responsibility of the applicant to submit all required supporting documents. The process may take several weeks. Failure to provide supporting documents or submit fingerprint cards in a timely manner may delay licensure. **Note:** The mailing and email address provided will be considered the address of record. It is the applicants' responsibility to maintain current contact information with the Board. Applications must be completed within twelve months of filing. ***Application fees are non-refundable.***

License by Examination Fee $220: Applicant has passed within 2 years of application, National Board and approved regional clinical exam. See Admin. Code 20-04-01-04.
BACKGROUND
Military Status: Are you are a member of OR a spouse of a member of the armed forces of the United States or a reserve component of the armed forces of the United States? ☐ YES ☐ NO (If yes, please provide proof of military/spouse status, such as military orders or current base ID)
Full Name (First, Middle, Last)
Maiden Name or Other Names Used
Name as you wish it to appear on license (must provide documentation of name change)

Social Security Number	Date of Birth
Home Address	Home Phone Cell phone
City State	Zip Code + 4
Email Address	
Employer Name	Office Address
City State	Zip Code + 4
Office Phone Number	Office Fax Number
Employer #2	Office Address
City	State Zip
Phone	Fax

EDUCATION	
Full Name of Dental Hygiene School	Location

Degree (attach a notarized copy of diploma)	Date of Graduation month/day/year
Other Education	Location
Degree (attach a notarized copy of diploma)	Date of Graduation month/day/year

EXAMINATIONS

National Board Dental Hygiene Examination: Attach a notarized copy of National Board Certificate. Number of attempts_____	Date Completed
Attach notarized copy of regional clinical licensure exam ☐Exam taken before 9/17/2009 ☐ CDCA-WREB ☐ CRDTS ☐CITA ☐ADEX Number of attempts_____	Date Completed
Attach notarized copy of regional clinical licensure exam ☐Exam taken before 9/17/2009 ☐ CDCA-WREB ☐ CRDTS ☐CITA ☐ADEX Number of attempts _____	Date Completed
Attach notarized copy of regional clinical licensure exam ☐Exam taken before 9/17/2009 ☐CDCA-WREB ☐CRDTS ☐CITA ☐ADEX Number of attempts _____	Date Completed

PROFESSIONAL BACKGROUND – Use additional pages if necessary

Have you been engaged in the clinical practice of dental hygiene preceding this application? If YES, list name and address of practice and inclusive dates of employment from the previous 3 years.	**YES**	**NO**

	Dates of employment
	Dates of employment
	Dates of employment

List ALL jurisdictions in which you have at any time been licensed to practice dental hygiene

Jurisdiction	Date Issued	Date Expired	License Number

DISCLOSURE

1. Has there been any investigation or disciplinary action taken against you by a dental hygiene school? If "YES", attach explanation.	**YES**	**NO**
2. Have you failed a licensing examination for **any** professional license?	**YES**	**NO**
3. Have you ever had an application for a professional license denied? If "YES", provide information on separate attachment.	**YES**	**NO**
4. Has any disciplinary action ever been instituted which could have affected or could now affect your license to practice in any state? If "YES", attach explanation.	**YES**	**NO**
5. Have you ever held a dental hygiene or dental license or certificate in another country?	**YES**	**NO**
6. Have you ever been subject to informal or formal proceedings by any licensing board, agency, or professional association to revoke, suspend, or limit a professional license? If "YES", attach documentation.	**YES**	**NO**
7. Has your license/registration or privileges to practice dental hygiene or dentistry ever been suspended, revoked or otherwise disciplined in any state or territory of the United States, or in any foreign country? If "YES", attach an explanation and provide copies of all judgments, decisions, and agreements?	**YES**	**NO**
8. Have you **ever** been charged or convicted, entered a plea of guilty, no contest, or a similar plea, or had a sentence deferred or suspended in any state or jurisdiction?	**YES**	**NO**

9. Have you ever been found in any civil, administrative or criminal proceeding to have: a. Possessed, used, prescribed for use, or distributed controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes?	**YES**	**No**
b. Been **cited** for operating a motor vehicle while under the influence of drugs or alcohol?	**YES**	**No**
c. Diverted controlled substances or legend drugs?	**YES**	**No**
d. Violated any drug law?	**YES**	**No**
e. Prescribed controlled substances for yourself?	**YES**	**No**
If you answered "yes" to the above questions you must send documentation such as certified copies of all court documents related to your criminal history with your application. If you do not provide the documents, your application is incomplete and will not be considered. Documentation may also include copy of evaluation and recommendations for treatment if any were issued; a copy of the criminal charges, reported offense, police report and judgment and disposition of criminal complaint; disposition of the offense, final disposition, any orders or any actions pending.		
10. Are you now subject to criminal prosecution or pending charges of a crime, felony or misdemeanor in any state or jurisdiction?	**YES**	**No**
11. Do you have criminal charges pending or are you now or have you ever been charged or convicted of any crime, felony or misdemeanor?	**YES**	**No**
If you answer "yes" to question (10) or (11), you must explain the nature of the prosecution and/or charge(s). You must include the jurisdiction that is investigating and/or prosecuting the charges. This includes any city, county, state, federal or tribal jurisdiction. If charging documents have been filed with a court, you must provide certified copies of those documents.		
12. Do you have or have you ever had any serious physical or mental illness? If "YES" attach explanation.	**YES**	**No**
13. Are you presently engaged in or have you or have you ever been engaged in the excessive use, abuse, addiction to or dependency upon any controlled substance, habit-forming substance or alcohol? If "YES" attach documentation including copy of evaluation and recommendations for treatment if any were issued; a copy of the criminal charges, reported offense, police report and judgment and disposition of criminal complaint; disposition of the offense, final disposition, any orders or any actions pending.	**YES**	**NO**
14. Have you ever been named in any civil suit or suffered any civil judgment for incompetence, negligence or malpractice in connection with the practice of a health care profession? If "YES", attach explanation.	**YES**	**NO**
15. Have you ever had **any** malpractice judgment, malpractice settlement, or governmental/private agency disciplinary order issued against you or is there any complaint, malpractice claim, or disciplinary action now pending against you? If "YES", attach explanation.	**YES**	**NO**
16. Submit a **Medical Evaluation and Authorization** form completed by a licensed physician or nurse practitioner attesting that you are physically and mentally able to perform the functions of the license you seek and that there are no medical considerations in your health history that might pose a threat to the patients you treat.		
17. Submit a **Medical Professional** Reference form and authorization to a licensed optometrist or ophthalmologist verifying your visual acuity is sufficient for the license you seek.		

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Affidavit of Applicant

State of _____)
ss.)
County of _____)

Paste Photograph Here

For identification purposes, applicant must furnish one passport size photograph taken not more than six months prior to the date of application.

Sign your name on the photo

I, _____, the applicant, being first duty sworn, certify that I am the person referred to in this application for licensure to practice dentistry in North Dakota, 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 North Dakota Board of Dentistry all information, files or records requested in connection with this application.

_____

APPLICANT'S SIGNATURE (Sign before a Notary Public)

Sworn to before me this _____ day of _____ 20 _____

MY commission expires _____

Notary Public Signature _____

The North Dakota Board of Dental Examiners will carefully review your application for licensure. You may be required to be present for a personal interview. Please note that intentional failure to provide complete information or to fully disclose the answers to the questions posted in this application or concealing relevant information needed by the board for a thorough review of your credentials may constitute fraud and may be considered as the basis for denial of license or revocation of any license which may have been issued to you.

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Medical Evaluation of License Applicant

Dear Doctor, The North Dakota Board of Dental Examiners is conducting a review of the professional credentials of an applicant for a license to practice dentistry or dental hygiene. One of the requirements for licensure is a statement by a licensed physician or nurse practitioner that the applicant has been examined within the last 2 years and found physically and mentally acceptable to engage safely in the practice of dentistry or dental hygiene.

Please document your professional assessment on the form below and send it directly to the Board's address at your earliest convenience. The applicant's authorization for you to provide this information directly to the North Dakota Board of Dental Examiners is provided below.

AUTHORIZATION TO CONDUCT BACKGROUND INVESTIGATION AND MEDICAL EVALUATION

I _____, authorize the NDBDE to review my medical, personal, and professional background so that my suitability to practice dentistry in the State of North Dakota can be evaluated. I hereby give my permission to the NDBDE to evaluate my clinical competence and suitability to practice by reviewing any aspect of my personal history, medical history, or any aspect of my history of professional practice which could in any way reflect on my suitability to practice dentistry or dental hygiene. I authorize any person or organization to provide any information to the NDBDE which bears on my suitability to practice dentistry or dental hygiene. Further, I agree to hold harmless any person or organization providing such information to the NDBDE. I understand and acknowledge that full disclosure of all material facts is required for the proper evaluation of my credentials. I understand that withholding significant information or facts constitutes grounds for not issuing a license or later revocation of any license which may have been issued base on incomplete, misleading or false information.

Signature of Applicant _____ Date _____

Address of Applicant _____

CONFIDENTIAL PROFESSIONAL REFERENCE AND MEDICAL EVALUATION

Applicant: _____

☐ I have examined the above named applicant and find no medical or mental condition, which precludes the safe practice of dentistry or dental hygiene. My examination reveals that the examinee is not chemically dependent, nor do I find that the examinee has any physical or mental disabilities.

OR

☐ I have examined the above named applicant and find the following conditions, which may have an impact on the applicant's ability to safely render health care to patients in the practice of dentistry or dental hygiene.

Comments:

_____
_____
_____
_____
_____

Physician Name (print)

Physician signature

Address Office phone

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Optometric Evaluation of License Applicant

Dear Doctor, The North Dakota Board of Dental Examiners is conducting a review of the professional credentials of an applicant for a license to practice dentistry or dental hygiene. One of the requirements for licensure is a statement by a licensed optometrist or ophthalmologist that the applicant has been examined within the last 2 years and found physically acceptable to engage safely in the practice of dentistry or dental hygiene.

Please document your professional assessment on the form below and send it directly to the Board's address at your earliest convenience. The applicant's authorization for you to provide this information directly to the North Dakota Board of Dental Examiners is provided below.

AUTHORIZATION TO CONDUCT BACKGROUND INVESTIGATION AND MEDICAL EVALUATION

I _____, authorize the NDBDE to review my medical, personal, and professional background so that my suitability to practice dentistry in the State of North Dakota can be evaluated. I hereby give my permission to the NDBDE to evaluate my clinical competence and suitability to practice by reviewing any aspect of my personal history, medical history, or any aspect of my history of professional practice which could in any way reflect on my suitability to practice dentistry or dental hygiene. I authorize any person or organization to provide any information to the NDBDE which bears on my suitability to practice dentistry or dental hygiene. Further, I agree to hold harmless any person or organization providing such information to the NDBDE. I understand and acknowledge that full disclosure of all material facts is required for the proper evaluation of my credentials. I understand that withholding significant information or facts constitutes grounds for not issuing a license or later revocation of any license which may have been issued base on incomplete, misleading or false information.

Signature of Applicant _____ Date _____

Address of Applicant _____

CONFIDENTIAL PROFESSIONAL REFERENCE AND MEDICAL EVALUATION

Applicant: _____

☐ I have examined the above named applicant and find the applicant's visual acuity is sufficient to permit the safe practice of dentistry or dental hygiene.

OR

☐ I have examined the above named applicant and find the following conditions, which may have an impact on the applicant's ability to safely render health care to patients in the practice of dentistry or dental hygiene.

Comments:

_____
_____
_____
_____

Optometrist Name (print) Optometrist Signature

Address

FINGERPRINT CRIMINAL RECORDS CHECK
FOR DENTISTS AND DENTAL HYGIENISTS APPLYING FOR
North Dakota Dental or Dental Hygiene License

DENTAL BOARD FINGERPRINT INFORMATION - Once your application for ND dental or dental hygiene license and license fee have been received by the North Dakota Board of Dental Examiners, two traditional ink fingerprint cards and instructions are mailed to the applicant. Delaying the fingerprinting process may delay your license.

A **North Dakota criminal history record check** is a search of confidential law enforcement databases, cross-referencing by the person's name, date of birth, social security number and other specific identifiers (including fingerprints). The extensive cross-referencing ensures that the result relates only to that person, even if the person has used several names or there are other individuals with the same name. Pursuant to the North Dakota Century Code, only the ND Bureau of Criminal Investigation (BCI) can supply a Criminal History Record Check.

FINGERPRINTS WILL BE USED TO CHECK THE CRIMINAL HISTORY RECORDS OF THE FBI. THE BOARD PROVIDES THE APPLICANT THE OPPORTUNITY TO COMPLETE, OR CHALLENGE THE ACCURACY OF, THE INFORMATION CONTAINED IN THE FBI IDENTIFCATION RECORD. APPLICANTS ARE ADVISED THAT PROCEDURES FOR OBTAINING A CHANGE, CORRECTION, OR UPDATING OF AN FBI IDENTIFICATION RECORD ARE SET FORTH IN TITLE 28, C.F.R., § 16.34. GRANTING OF LICENSURE SHALL NOT BE BASED ON INFORMATION IN THE RECORD UNTIL THE APPLICANT HAS BEEN AFFORDED A REASONABLE TIME TO CORRECT OR COMPLETE THE RECORD, OR HAS DECLINED TO DO SO.

- Applicants may have their fingerprints rolled by a local Law Enforcement Agency or other Board approved agent. Be prepared to pay a fee for having the fingerprint card executed. The fingerprints must be taken by an appropriately trained official. The fingerprint card must be signed by the official in the appropriate block.
- Additional fingerprint cards are available from the Dental Board upon request.
- Ensure that fingerprint cards are completely filled out. Required information includes: Full name, social security number, date of birth, home address, sex, height, weight, hair color, eye color, place of birth etc.
- "**Reason Fingerprinted**" should specify the type of license you are applying for (Dental or Dental Hygiene Licensure)
- Please be advised that if your fingerprint cards are rejected, you will be notified and processing of your application may be delayed. Do not attempt to take your own fingerprints. They will be rejected.
- Mail the fully completed card, along with the fee as instructed on the card to:
  NDBDE, PO Box 7246, Bismarck, ND 58507-7246.

FAILURE TO DISCLOSE CRIMINAL HISTORY

Before you submit any application, please be aware that failure to disclose disciplinary actions, convictions, arrests or charges is grounds for denial or revocation of license. There are no exceptions under which omission of this information in the application or renewal process is deemed acceptable. It should be noted that such information does not automatically disallow licensure. However, disqualification may occur by failing to answer all questions honestly. Read each question on your application carefully.

Examples of past unacceptable explanations provided in "failure to report" incidents to the Board include:

- ⃠ I didn't think I had to mention the DUI because I paid all of the fines.
- ⃠ I didn't think the disciplinary action, arrest, charge, or conviction was still on my record and I was told it was expunged.
- ⃠ My attorney told me I didn't have to disclose the criminal conduct or disciplinary actions.
- ⃠ I didn't think the prior conduct had anything to do with the profession.
- ⃠ I didn't think it was subject to disclosure because I received a deferred sentence/judgment.
- ⃠ I didn't read the question carefully enough.

New license applications and license renewal applications contain questions related to disciplinary actions, illegal or errant behavior and criminal conduct. After receiving a professional license, all license holders continue to be subject to reporting requirements regarding any disciplinary actions, charges or convictions, regardless of in what state they might occur. Please review NDCC § 43-28-18.1. Duty to Report.

VERIFICATION OF DENTAL/DENTAL HYGIENE LICENSE

Please forward one form to each state dental/dental hygiene board where you hold or have ever held a dental/dental hygiene license. Some states require a fee, paid in advance, for providing this information.

I am making application for licensure in North Dakota by:

[ ] Examination for Dental License
[ ] Examination for Dental Hygiene License
[ ] Reinstatement of ND License
[ ] Credentials for Dental License
[ ] Credentials for Dental Hygiene License
[ ] Temporary License

The North Dakota State Board of Dental Examiners requests that I submit evidence that my license is in good standing. You are hereby authorized to release any information in your files, favorable or otherwise directly to:

ATTN: Executive Director
North Dakota Board of Dental Examiners
PO Box 7246
Bismarck, ND 58507-7246

_____ _____

Applicant's Typed/Printed Name Applicant's Signature

_____

Applicant's Address City State Zip+4

Executive Officer of State Board: Please return this form DIRECTLY to the Executive Director, North Dakota Board of Dental Examiners.

State of _____ Name of Licensee_____

License #_____ Issue Date _____

By ☐ Reciprocity ☐ Examination ☐ Credential/Endorsement

License is: ☐ Current and Expires on _____ ☐ Active ☐ Inactive ☐ Lapsed-Expired _____/_____/_____

Has applicant's license ever been disciplined, suspended or revoked ☐ NO ☐ YES

If yes, give details and attach supporting documentation (Finding of Fact, Conclusions of Law, Orders):_____

_____

Comments:_____

Signature _____

Title_____

SEAL

Date _____/_____/_____

6/2021

North Dakota Board of Dental Examiners

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Application and Instructions for RDH Local Anesthesia Permit

OFFICE USE ONLY - Postmark Date: _____ Date Received _____ Amount _____ Check # _____

A licensed dental hygienist may apply for a permit to administer local anesthesia to a patient who is at least eighteen years old under the direct supervision of a dentist. Qualified applicants must successfully complete a board approved course within 24 months of application or provide a written statement from the dentist who directly supervised the applicant attesting to experience in administering local anesthesia within the previous three years and provides evidence of a board approved course. See Administrative Rule 20-04-01-03.

TYPE OR PRINT LEGIBLY. INCOMPLETE APPLICATIONS WILL BE RETURNED TO THE APPLICANT.		
Full Name (First, Middle, Last)		ND License Number
Address		Cell Phone
City	State	Zip
Work Address		
City	State	Zip
Email		Home Phone
LOCAL ANESTHESIA COURSE INFORMATION		
Name of Anesthesia Training Program		
Location of Local Anesthesia Course		
Name of Instructor/Program presenter		Date of Last CPR course
Number of CE credits or college credits		Date Program Completed

☐ **I certify that I have successfully completed within the last 24 months a didactic and clinical course in local anesthesia, sponsored by a dental or dental hygiene program accredited by the Commission on Dental Accreditation. I submit notarized proof of this course.**
Applicant Signature:

OR

☐ **I certify that I have been permitted to administer local anesthesia in another jurisdiction and have continually administered local anesthesia during the past three years and I submit a notarized letter from a licensed dentist to confirm continuous use of local anesthetic and in addition I submit a notarized copy of proof of successful completion of a board approved local anesthesia course.**
Applicant Signature:

Print name of dentist attesting to continuous use of local anesthesia:		Office Phone
Work Address		
City	State	Zip

Submit with this form:

1. **Notarized copy of anesthesia course certificate of completion**
   OR notarized copy of dental hygiene transcript with LA course recorded;
2. **Letter from licensed dentist if required;**
3. **Affidavit of a True Copy**

Note: When a notary makes an attested copy of a document, he/she is not guaranteeing the authenticity of the original document, its contents, or its effects. The notary is simply stating that the document photocopy is a "true" and complete copy of the original document that was presented. The notary's certification is made in a notarial certificate worded expressly for this purpose.

AFFIDAVIT OF A TRUE COPY

State of _____

County of _____

On this _____ day of _____, 20____, I certify that the preceding or attached document is a true, exact, complete and unaltered photocopy made from the original document _____ description of document), presented to me by _____(name of custodian) and that, to the best of my knowledge, the photocopied document is neither a public record nor a publicly recorded document.

[SEAL]

_____
Signature of Notary Public

_____
Printed Name of Notary Public

This space for office use only.

Rev. 10/1/2021