North Dakota State Board of Dental Examiners

PO Box 7246, Bismarck, ND 58507-7246 • Phone 701-258-8600
Web www.nddentalboard.org • Email info@nddentalboard.org

Application – Local Anesthetic Permit

Who May Apply

- Applicants must be one of the following in order to apply for a Local Anesthetic Permit:
  - Registered Dental Hygienist
  - An individual applying to be a Registered Dental Hygienist

Applicable Laws for Local Anesthetic Permit

- N.D.A.C. 20-04-01-03(2) explains the criteria for those seeking a Local Anesthetic Permit.
- N.D.A.C. 20-04-01-03(3) explains the duties a permit holder may perform, and the levels of supervision.
- Applicants must thoroughly review N.D.A.C. 20-04 and be able to demonstrate an understanding of the laws cited above.

- **Application**
- Be sure to attach/download additional materials and documents as requested.
- If you have questions on the application and or materials, please email us at: info@nddentalboard.org

Accepted Forms of Payment

- Check (personal/cashiers).
- Online payment through debit or credit card (once online payments are available on the Board's website).
- Unacceptable forms of payment include cash, money orders, and American Express cards.

Contact Information and Names

- Current and complete contact information is required for all applicants. Email addresses must be included on the application and will be used by the Board related to the processing of your application.
- Submit documentation of any legal name change.
- If your application is granted, you must always update the Board with any change of name, address, email address, phone, employers, and other contact information. Failure to do so can result in you not receiving critical information in a timely manner and may result in discipline.

North Dakota State Board of Dental Examiners

PO Box 7246, Bismarck, ND 58507-7246 • Phone 701-258-8600
Web www.nddentalboard.org • Email info@nddentalboard.org

Application–Local Anesthetic Permit

Non-refundable Fee: $50.00

OFFICE USE ONLY - Postmarked:_____ Received: _____ Amount:_____Payment Type: Check #_____Online #_____

General Contact Information			
Legal First Name	Legal Middle Name	Legal Last Name	Today's Date (mm/dd/yyyy)
Other Legal Names Previously Used (include proof of legal name changes and indicate if exam scores use these names)			
Name as you wish it to appear on license (if not your current legal name, you must provide documentation of name change)			
Home Street Address	Apt. Number	Home City, State, Zip (4+ digits)	
Phone Numbers (c) (h) (w)	Business/Employer Name, Address, Unit #	Employer/Business City, State, Zip (4+ digits)	
Personal Email Address **(required)**	Business/Employment Email Address		
Gender Male ☐ Female ☐ X ☐	Date of Birth (mm/dd/yyyy)	Social Security Number	

Military Status: Are you a member of the armed forces of the United States or a reserve component of the armed forces of the United States stationed in this state in accordance with military orders or stationed in this state before a temporary assignment to duties outside of this state; or are you the spouse of such member? Yes ☐ No ☐

Attach military orders, duty station assignment, base identification, etc. Depending on submissions, your application may be processed as a military application.

Education (select one)	
☐ Within five years of this application, completed a didactic and clinical course in local anesthesia sponsored by a dental or dental hygiene program accredited by CODA resulting in the dental hygienist becoming clinically competent in the administration of local anesthesia.	Name of Program: _____ Location of Program: _____ Date of Completion: _____ Submit certification of completion.

The applicant submits all of the following: ☐ Proof that the applicant was authorized by another jurisdiction to administer local anesthetic (e.g., the type of authorization such as a license, permit, or endorsement); ☐ A verification document attesting that during the last five years, the applicant competently administered local anesthetic. The verification document must be submitted **directly from the dentist or school** to the Board, and can be either: (1) a letter from the accredited school with the school seal affixed; (2) a notarized copy of the certification of the local anesthesia course; or (3) a notarized letter from a supervising, licensed dentist.	Other state: _____ Authorization type:_____ Verifying School: _____ Or Name of Dentist: _____ Submit certification of completion.

Cardiopulmonary Resuscitation or Basic Life Support (applicants must hold either current CPR or BLS certification)
Hold an active cardiopulmonary resuscitation (CPR) certification; course must include a hands-on component. Yes ☐ No ☐ Expiration date: _____ Basic life support (BLS) certification. Yes ☐ No ☐ Expiration date: _____ Attach certificates.

Attestation of Applicant		
I have reviewed North Dakota Century Code §§ 43-20-05 and 43-28-25, and understand that including false information or false documentation in this application may result in denial of my application and could result in a class A misdemeanor.		Yes ☐ No ☐
I certify that I am the person referred to in this application.		Yes ☐ No ☐
I certify that the entirety of this application and the attached materials are true and correct.		Yes ☐ No ☐
I authorize all persons and organizations to release any requested information, files, or records in connection with this application to the North Dakota State Board of Dental Examiners.		Yes ☐ No ☐
Applicant's Name (Printed)	Applicant's Signature	Date (mm/dd/yyyy)