

## **Denturist License Application Packet**

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### **Important Social Security Number Information:**

You are required by state and federal law to provide a social security number with your application. If you do not have a social security number at the time you send in this application, please read, complete, and return this [form](#) with your application.

A U.S. Individual Taxpayer Identification Number (ITIN) or a Canadian Social Insurance Number (SIN) cannot be substituted.

### **In order to process your request:**

**Mail your application with initial documentation and your check or money order payable to:**

Department of Health  
P.O. Box 1099  
Olympia, WA 98507-1099

**Send other documents not sent with initial application to:**

Board of Denturists Credentialing  
P.O. Box 47877  
Olympia, WA 98504-7877

### **Contact us:**

360-236-4700

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## Application Instructions Checklist

**Important background check Information:** Washington State law authorizes the Department of Health to obtain fingerprint-based background checks for licensing purposes. This check may be through the Washington State Patrol and the Federal Bureau of Investigation (FBI). This may be required if you have lived in another state or if you have a criminal record in Washington State. This would be at your own expense.

All information should be printed clearly in blue or black ink. It is your responsibility to submit the required forms.

**Application Fee.** This fee is non-refundable. You can check the online [fee page](#) for current fees.

**Check if either apply:**  
Request for Military Training and Experience Evaluation  
Spouse or Registered Domestic Partner of Military Personnel

**1. Demographic Information:**

**Social Security Number:** You must list your social security number on your application. Please call the Customer Service Center at 360-236-4700 if you do not have one.

**National Provider Identifier Number (NPI):** The National Provider Identifier (NPI) is a standard unique identifier for health care professionals available from the Federal Centers for Medicare and Medicaid Services. The NPI is a 10 digit numeric identifier. If you have a NPI number, provide this on your application.

**Legal Name:** List your full name: first, middle, and last.

**Definition of legal name:** “Legal name” is the name appearing on your official certificate of birth or, if your name has changed since birth, on an official marriage certificate or an order by a court. The court must have the legal authority to change your name. We may ask you to prove your legal name. If you use any name other than your legal name on this form, your application may be denied.

**Birth date:** Provide month, day, and year of your birth.

**Place of Birth:** Provide the city, state, and country where you were born.

**Address:** List the address we should use to send any information. Be sure to include the city, state, zip code, county, and country. This will be your permanent address with the Department of Health until we have been notified of a change. See [WAC 246-12-310](#).

**Phone, Fax and Cell Numbers:** Enter your phone, fax and cell numbers, if you have them.

**Email:** Enter your email address, if you have one.

**Other Name(s):** Indicate whether you are known or have been known under any other names. If you have a name change, you must notify the Department of Health in writing. You must include proof of this change. See [WAC 246-12-300](#).

**2. Personal Data Questions:**

All applicants must answer the same personal data questions. They are focused on your fitness to practice the essential skills of this profession.

If you answer “yes” to any questions in this section, you must provide an appropriate explanation. You must also provide the documentation listed in the note after the question. If you do not provide this, your application is incomplete and it will not be considered.

- Question 5 includes misdemeanors, gross misdemeanors and felonies. You do not have to answer yes if you have been cited for traffic infractions. You can get copies of court records through the county courthouse where the conviction, plea, deferred sentence, or suspended sentence was entered.
- Another jurisdiction means any other country, state, federal territory, or military authority.

**3. Education:**

List in date order your educational preparation and post-graduate training. Attach additional pages if you need more space.

**4. Experience:**

List in date order all experience and practice from date of graduation from professional college. Attach additional pages if you need more space.

**5. Other License, Certification, or Registration:**

List all states where credentials are or were held. List all active, inactive and expired credentials. Specifically list credentials granted as temporary, reciprocity, exemption or similar with type, date, grantor, and if credential is current.

**6. AIDS Education and Training Attestation:**

Read the AIDS education and training attestation. AIDS training may include self-study, direct patient care, courses, or formal training. A minimum of seven hours is required. Course content can be found in [WAC 246-12-270](#). If AIDS education was included in your professional education or training, an additional course is not required.

**7. Applicant’s Attestation:**

You must sign and date this for us to process the application.

## **For Spouses and Registered Domestic Partners of Military Personnel Being Transferred or Stationed in Washington:**

Under state law, if you are the spouse or state-registered domestic partner of a servicemember of any branch of the U.S. Military, to include Guard or Reserve, and are applying for a health care professional credential in this state, you may be eligible to have the processing of your application expedited to receive your credential more quickly.

Documents to submit with your application should include the following:

- A copy of your spouse's or registered domestic partner's military transfer orders to Washington State.
- One of the following:
  - A copy of your marriage certificate to show proof of marriage; or
  - A copy of a state's declaration or registration showing you are in a state registered domestic partnership with a member of the U.S. military.

## **For Current and Former Servicemembers Requesting Evaluation of Military Training and Experience**

Under state law, your military education, training, and experience may count towards attaining certain civilian health care profession credentials in Washington State.

Submitted information will be reviewed by the Department of Health to determine substantial equivalency for meeting the credentialing requirements in this state.

Documents to submit with your health care professional credential application should include the following:

- If applicable, a copy of your DD214 Certificate of Release or Discharge from Active Duty, Member-4 or service 2 copy, or NGB-22 for National Guard.

**Please note:**

- A copy of your DD214 can be downloaded from the [EBenefits website](#).
- You can request a replacement copy of your NGB-22 on the [National Archives website](#).
- Official Joint Service Transcript (JST) or Community College of the Air Force(CCAF) Transcripts.

**Please note:**

  - JST can be sent electronically by visiting the [JST website](#) and selecting Washington State Department of Health.
  - CCAF transcripts cannot be sent electronically. See the [CCAF website](#) for transcript information.
- Verification of Military Experience and Training (VMET) or DD Form 2586. See the [DoDTAP website](#).
- If applicable, application for the Evaluation of Learning Experiences During Military Service (DD Form 295). See the [Military Resources website](#).

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## License Requirements

Thank you for applying to become a licensed denturist in Washington State. You need this application if you have completed one of the following:

### **Endorsement.** [RCW 18.30.090\(1\)\(a\)\(b\)](#)

1. Proof of successfully passing both a written and clinical examination for denturism in a state that has equivalent licensing standards as those in Washington State.

The following states have been determined to meet the equivalency standards:

- Maine (if applicant completed a Washington board approved denturist program and was licensed prior to July 1, 2012);
- Montana (if the applicant completed a Washington board approved denturist program and was licensed by examination and not endorsement); and
- Oregon (if the applicant completed a Washington board approved denturist program and the examinations were passed prior to March 1, 2015.)

**Note: Board approved denturist programs are listed below.**

2. An affidavit from the state agency where the person is licensed or certified, attesting to the fact of the applicant's license or certification.

**Examination.** There is one category of eligibility for license through examination:

Education: [RCW 18.30.090\(2\)](#), provides eligibility for applicants who have the following:

- a. Documentation of successful completion of formal training with a major course of study in denturism of not less than two years duration at an educational institution approved by the board; and
- b. Passes a written and clinical examination approved by the board.

The following educational programs have been approved by the board:

- American Denturist College, Eugene, Oregon
- Bates Technical College, Tacoma, Washington
- George Brown College, Ontario, Canada.
- New England School of Denture Technology, Bangor, Maine
- Northern Alberta Institute of Technology (NAIT), Alberta, Canada.
- Vancouver Community College, Vancouver, British Columbia, Canada (completion after 2000 and prior to July 2015).

To expedite the license process, be sure the following information is included with your application.

- Non-refundable application fee. See [fee page](#).
- Non-refundable examination fee (only if you are applying by examination). See [fee page](#).

The following require primary source verification. They are accepted when mailed directly to the department from the source. These items should not be included with your application. They should be sent directly to the Department of Health, P.O. Box 47877, Olympia, WA 98504-7877.

- Official denturist transcripts showing degree and date degree was conferred.
- Verification of license from every state in which you hold or have ever held a health care practitioner license.
- Verification of passing written and clinical exam (if applying by endorsement).

#### **Jurisprudence Examination:**

- Complete the [online examination](#).
- Print and send your certificate of completion with your application. It is a multiple-choice exam and designed to familiarize you with the Washington State dentistry laws. See [RCW 18.30](#) for current laws and [WAC 246-812](#) for current rules.

The online jurisprudence examination must be completed prior to being scheduled for the written and/or clinical examinations.

#### **Examination:**

The completed application, supporting documents and fees are due 60 days prior to the scheduled exam date for which you are applying. When you are approved for the exam, notification of the time and place will be mailed to you, at the last known address, approximately thirty days prior to the examination date.

The Denturist Written and Practical Exam are scheduled at least once a year. The number of candidates and availability of exam facility determine the exact dates. If there are less than five candidates, the practical exam will not be given and will be moved to the next exam date.

Individuals interested in taking the Washington State Denturist Examination should contact Health Professions and Facilities at 360-236-4865 for information regarding the schedule.

#### **Business Address:**

The law requires your license to contain, on its face, the address or addresses where you will perform the denturist services. Prior to treating patients, submit to the Department your business address or addresses.

You will be notified in writing if further documentation is required.

- The initial license will expire on your birthday unless the license is issued within 90 days of your next birthday. See [WAC 246-12-020 \(3\)](#).
- You will receive a courtesy renewal notice if your license and address are kept up to date. Any renewal postmarked or presented to the department after midnight on the expiration date is late.

Information regarding the denturist program is also available on our [website](#).

**Note: You cannot practice denturism until your license is issued.**

Date  
Stamp  
Here

Revenue 0251080000

## Denturist License Application

**Check one:**  Licensure by Examination     Licensure by Endorsement of Credentials and Examination

**Select if either apply:**     Request for Military Training and Experience Evaluation  
 Spouse or Registered Domestic Partner of Military Personnel

### 1. Demographic Information

<b>Social Security Number (SSN)</b> (If you do not have a SSN, see instructions)	<b>National Provider Identifier Number (NPI)</b> (Enter 10 digit number)	<input type="checkbox"/> Male <input type="checkbox"/> Female
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Name	First	Middle	Last
------	-------	--------	------

Birth date (mm/dd/yyyy)	<b>Place of birth</b>		
	City	State	Country

Address

City	State	Zip Code	County
------	-------	----------	--------

Country

Phone (enter 10 digit #)	Fax (enter 10 digit #)	Cell (enter 10 digit #)
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Email address

Mailing address if different from above address of record

City	State	Zip Code	County
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Country

**Note:** The mailing and email addresses you provide will be your addresses of record. It is your responsibility to maintain current contact information on file with the department.

Have you ever been known under any other name(s)?  Yes     No

If yes, list name(s):

Will documents be received in another name?  Yes     No

If yes, list name(s):

## 2. Personal Data Questions

Yes No

1. Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please attach explanation.....

**“Medical Condition”** includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, intellectual disabilities, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction, and alcoholism.

If you answered yes to question 1, explain:

- 1a. How your treatment has reduced or eliminated the limitations caused by your medical condition.  
1b. How your field of practice, the setting or manner of practice has reduced or eliminated the limitations caused by your medical condition.

**Note: If you answered “yes” to question 1, the licensing authority will assess the nature, severity, and the duration of the risks associated with the ongoing medical condition and the ongoing treatment to determine whether your license should be restricted, conditions imposed, or no license issued.**

**The licensing authority may require you to undergo one or more mental, physical or psychological examination(s). This would be at your own expense. By submitting this application, you give consent to such an examination(s). You also agree the examination report(s) may be provided to the licensing authority. You waive all claims based on confidentiality or privileged communication. If you do not submit to a required examination(s) or provide the report(s) to the licensing authority, your application may be denied.**

2. Do you currently use chemical substance(s) in any way which impair or limit your ability to practice your profession with reasonable skill and safety? If yes, please explain.....

**“Currently”** means within the past two years.

**“Chemical substances”** include alcohol, drugs, or medications, whether taken legally or illegally.

3. Have you ever been diagnosed with, or treated for, pedophilia, exhibitionism, voyeurism or frotteurism?.....

4. Are you currently engaged in the illegal use of controlled substances?.....

**“Currently”** means within the past two years.

**Illegal use of controlled substances** is the use of controlled substances (e.g., heroin, cocaine) not obtained legally or taken according to the directions of a licensed health care practitioner.

**Note: If you answer “yes” to any of the remaining questions, provide an explanation and certified copies of all judgments, decisions, orders, agreements and surrenders. The department does criminal background checks on all applicants.**

5. Have you **ever** been convicted, entered a plea of guilty, no contest, or a similar plea, or had prosecution or a sentence deferred or suspended as an adult or juvenile in any state or jurisdiction? ...

**Note: If you answered “yes” to question 5, you must send 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.**

**To protect the public, the department considers criminal history. A criminal history may not automatically bar you from obtaining a credential. However, failure to report criminal history may result in extra cost to you and the application may be delayed or denied.**

## 2. Personal Data Questions (cont.)

Yes No

6. 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? .....
  - b. Diverted controlled substances or legend drugs? .....
  - c. Violated any drug law? .....
  - d. Prescribed controlled substances for yourself? .....
7. Have you ever been found in any proceeding to have violated any state or federal law or rule regulating the practice of a health care profession? If "yes", please attach an explanation and provide copies of all judgments, decisions, and agreements? .....
8. Have you ever had any license, certificate, registration or other privilege to practice a health care profession denied, revoked, suspended, or restricted by a state, federal, or foreign authority? .....
9. Have you ever surrendered a credential like those listed in number 8, in connection with or to avoid action by a state, federal, or foreign authority? .....
10. 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? .....
11. Have you ever been disqualified from working with vulnerable persons by the Department of Social and Health Services (DSHS)? .....

## 3. Education

List in date order your educational preparation. Attach additional completed pages if you need more space.

Schools Attended Full Name, City and State	Degree Earned	Attendance Dates	
		Start (mm/yyyy)	End (mm/yyyy)

## 4. Experience

List in date order all professional experience and practice from date of graduation from professional college. Include the month/day/year. Attach additional completed pages if you need more space.

Name of Business	Total Number of Months	Dates	
		Start (mm/yyyy)	End (mm/yyyy)

## 5. Other License, Certification, or Registration

List all states where credentials are or were held. Specifically list credentials granted as temporary, reciprocity, exemption or similar with type, date, grantor, and if credential is current. Attach additional completed pages if you need more space.

State Jurisdiction	License Number	License		Method of License
		Issue Date	Expiration Date	

## 6. AIDS Education and Training Attestation

I certify I have completed the minimum of seven hours of education in the prevention, transmission and treatment of AIDS. This includes the topics of etiology and epidemiology, testing and counseling, infection control guidelines, clinical manifestations and treatment, legal and ethical issues to include confidentiality, and psychosocial issues to include special population considerations.

I understand I must maintain records documenting said education for two years and be prepared to submit those records to the department if requested. **I understand that should I provide any false information, my license may be denied, or if issued, suspended or revoked.** If AIDS education was included in your professional education or training, an additional course is not required.

Applicant's Initials	Date

## 7. Applicant's Attestation

I, \_\_\_\_\_, declare under penalty of perjury under the laws of  
(Print applicant name clearly)  
the state of Washington the following is true and correct:

- I am the person described and identified in this application.
- I have read [RCW 18.130.170](#) and [RCW 18.130.180](#) of the Uniform Disciplinary Act.
- I have answered all questions truthfully and completely.
- The documentation provided in support of my application is accurate to the best of my knowledge.
- I have read all laws and rules related to my profession.

I understand the Department of Health may require more information before deciding on my application. The department may independently check conviction records with state or federal databases.

I authorize the release of any files or records the department requires to process this application. This includes information from all hospitals, educational or other organizations, my references, and past and present employers and business and professional associates. It also includes information from federal, state, local or foreign government agencies.

I understand I must inform the department of any past, current or future criminal charges or convictions. I will also inform the department of any physical or mental conditions that jeopardize my ability to provide quality health care. If requested, I will authorize my health providers to release to the department information on my health, including mental health and any substance abuse treatment.

Dated \_\_\_\_\_ at \_\_\_\_\_  
(mm/dd/yyyy) (City, state)

By: \_\_\_\_\_  
(Original Signature of Applicant)

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Washington State Department of  
**Health**

Board of Denturists Credentialing  
P.O. Box 47877  
Olympia, WA 98504-7877  
360-236-4700

## Out-of-State Credential Verification

### To Applicant:

Please complete this side of form and send it to the state(s) and/or jurisdiction(s) where you are or have been licensed, certified, or registered as a healthcare provider. Instruct them to return the form directly to the address listed above. Make a copy of this form if you need to send it to more than one state or jurisdiction. Agencies normally charge a fee for verification. Please check in advance to help expedite this process.

Name: Last		First	Middle
Mailing Address			
City		State	Zip Code
Any other names used:			
Type of healthcare license, certification, or registration:			
License, Certification, or Registration Number		Date Issued	

Have the licensing agency return this completed form to the address listed above.

If you have any questions, please call 360-236-4700.

**(To be Completed by the Regulatory Agency)**

Please complete this form regarding the applicant listed on the reverse. Submit the completed form and any other requested material directly to this office at the address on the reverse. We will not accept the form if submitted by the applicant. Thank you.

Name of license, certification, or registration holder:		
Authority providing verification: (state, name and title)		
Applicant was credentialed by: <input type="checkbox"/> Written Examination	Date:	Score:
Name of examination:		
<input type="checkbox"/> Other Examination	Date:	Score:
Name of examination:		
Is credential current: <input type="checkbox"/> Yes <input type="checkbox"/> No	Expiration Date:	
Is this individual considered to be in good standing in your state? <input type="checkbox"/> Yes <input type="checkbox"/> No If "no," please attach explanation.		
Has this credential ever been denied?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Suspended?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Revoked?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Surrendered?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Reinstated?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
If "yes," please provide a copy of the final order or other documentation of action taken.		
If this credential holder has been disciplined, has he/she successfully completed all requirements and is currently in good standing? <input type="checkbox"/> Yes <input type="checkbox"/> No		

(SEAL)

\_\_\_\_\_  
Signature:

\_\_\_\_\_  
Title:

\_\_\_\_\_  
Date:



# Washington State Board Of Denturists

## Written Examination Blueprint

Head and Oral Anatomy .....	8.10%
Oral Pathology .....	20.24%
Partial Denture Construction .....	12.15%
Microbiology .....	6.07%
Clinical Dental Technology .....	20.24%
Dental Laboratory Technology .....	12.15%
Clinical Jurisprudence .....	2.83%
Asepsis .....	10.12%
Cardiopulmonary Resuscitation and Medical Emergencies .....	4.86%
Geriatrics .....	1.23%

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## **RCW/WAC and Online Website Links**

### **RCW/WAC Links**

[Uniform Disciplinary Act, RCW 18.130](#)

[Administrative Procedure Act, RCW 34.05](#)

[Administrative Procedures and Requirements, WAC 246-12](#)

[Denturists Laws, RCW 18.30](#)

[Board of Denturists Rules, WAC 246-812](#)

### **Online**

[AIDS Training Resources, Reference Page](#)

[Board of Denturists, Web page](#)