



Washington State Department of
Health
Dental Hygiene Credentialing
P.O. Box 47877
Olympia, WA 98504-7877
360-236-4700

Out-of-State Credential Verification

To Applicant:

Please complete this side of this form and send it to the state(s), jurisdiction(s) or Canadian provinces where you are or have been licensed, certified, or registered as a healthcare provider. The regulatory agency will complete pages two and three.

| | | | |
|---|--|-------------------------|----------|
| Name: Last | | First | Middle |
| Mailing Address | | | |
| City | | State | Zip Code |
| Phone (enter 10 digit #) | | Cell (enter 10 digit #) | |
| Email address | | | |
| Any other names used | | | |
| Type of license(s) you hold or have held in other state(s), jurisdiction(s) or Canadian provinces | | | |
| Washington State healthcare credential type you are applying for | | | |
| Washington State healthcare credential number (if available) | | Date Issued | |

Have the licensing agency complete page two and return this form to the address listed above. If you have any questions, please call 360-236-4700.

This form may be duplicated.

(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, jurisdiction or Canadian province, name, and title) | | |
| Applicant was credentialed by: | Date: | Score: |
| <input type="checkbox"/> Written Examination | | |
| 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 or Canadian province? <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 | | |



Signature: _____

Title: _____

Date: _____

(To be Completed by the Regulatory Agency)

As of July 2006, the following states are not approved by the Washington State Dental Hygiene Program to have a substantially equivalent scope of practice:

- Delaware,
- Indiana,
- Kentucky,
- New York.

The state, jurisdiction, or Canadian province of _____ allows the following scope of dental hygiene practice:

| Yes | No | |
|-------|-------|---|
| _____ | _____ | (a) Oral inspection and measuring of periodontal pockets; |
| _____ | _____ | (b) Patient education in oral hygiene; |
| _____ | _____ | (c) Taking intra-oral and extra-oral radiographs; |
| _____ | _____ | (d) Applying topical preventive or prophylactic agents; |
| _____ | _____ | (e) Polishing and smoothing restorations; |
| _____ | _____ | (f) Oral prophylaxis and removal of deposits from the surface of the teeth; |
| _____ | _____ | (g) Recording health histories; |
| _____ | _____ | (h) Taking and recording blood pressure and vital signs; |
| _____ | _____ | (i) Performing subgingival and supragingival scaling; and |
| _____ | _____ | (j) Performing root planing. |

I further certify this information is true and correct to the best of our knowledge.



Authority Providing Verification _____
State, jurisdiction or Canadian province

Name _____

Signature _____

Title _____

Date _____

This Form May Be Duplicated