



## **Dental Hygiene Limited License First Time Renewal 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:**

Dental Hygiene 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 correct forms required.

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

**Select if the following applies:**  
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 your month, day and year of birth.

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

**Address:** List the address we should use to send any information about your license. 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. Other License, Certification, or Registration.** List in date order, most recent to later, all credentials you have held since last being credentialed in Washington State. Include your last active credential in Washington State. An out of state credential verification form must be resubmitted if it has been over six months since it was last received. Attach additional pages if you need more space.
- 3. Professional Experience.** In date order, most recent to later, list all your professional work experience since your Washington State credential expired. Attach additional pages if you need more space.
- 4. AIDS Education and Training Attestation.** Required by [WAC 246-12-040](#). If AIDS education was included in your professional education or training, an additional course is not required.
- 5. Disciplinary Action Attestation.** Required by [WAC 246-12-040](#).
- 6. Continuing Education Attestation.** Required by [WAC 246-12-040](#).
- 7. Applicant's Attestation.** Required to be both signed and dated in order 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.

## **First Time Renewal License Requirements**

The initial limited dental hygiene license is valid for 18 months. The limited license can be renewed, but the restorative endorsement can not.

In order to renew for the first time there are documents that you must submit.

**Please note:** If the department has already received any of the following documents for your initial limited dental hygiene license, you do not need to resubmit them.

### **Submit the following:**

- Verification of successful completion of an approved dental hygiene patient evaluation/prophylaxis (clinical hygiene) exam.

Please have a letter of verification sent directly from the qualifying testing agency. It must show completion of the patient evaluation/prophylaxis (clinical hygiene) exam.

We accept the following regional exams: Western Regional Examining Board (WREB), Central Regional Dental Testing Services (CRDTS), and North East Regional Board (NERB). We will accept the NERB exam for the time period of January 1, 2000 to August 21, 2009 only.

- Verification of successful completion of an approved local anesthesia exam.

Provide a letter of verification sent directly from WREB showing successful completion of the local anesthesia exam.

- Verification of successful course completion of didactic and clinical competency in the administration of nitrous oxide analgesia and local anesthesia.

Submit the applicable dental hygiene expanded function education verification form. The form is for either your dental hygiene ADA accredited program or the secretary approved courses. We do accept a combination of verifications.

Listed below is the contact information for WREB, CRDTS, and NERB.

Western Regional Examining Board  
23460 North 19th Ave., Suite 210  
Phoenix, Arizona 85027  
602-944-3315

Central Regional Dental Testing Service, Inc.  
1725 S.W. Gage Blvd.  
Topeka, Kansas 66604-3333  
782-273-0380

North East Regional Board of Dental Examiners, Inc.  
8484 Georgia Ave., Suite 900  
Silver Springs, Maryland 20910  
301-563-3300

(Accepted 01/01/2007 to 08/21/2009)

## **Other Information**

Criminal history checks are conducted for all license applicants. If your renewal application is incomplete, you will be mailed a letter regarding the deficiencies.

- The renewal application is considered incomplete if requested information is left blank. Write N/A or place a line through section instead of leaving blank.
- 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 \(3\)](#).
- A courtesy renewal notice will be mailed to your address on record. You must keep your address current with us. Any renewal postmarked or presented to the department after midnight on the expiration date is late.

Date  
Stamp  
Here

Revenue: 0251040000

## Dental Hygiene Limited Licensed First Time Renewal

Please print clearly. It is the responsibility of the applicant to submit or request all required supporting documents be submitted. Failure to do so may result in a delay in processing your application.

Limited License First Time Renewal     Initial Limited License Number \_\_\_\_\_

**Select if the following applies:**     Spouse or Registered Domestic Partner of Military Personnel

### 1. Demographic Information

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

|      |       |        |      |
|------|-------|--------|------|
| Name | First | Middle | Last |
|------|-------|--------|------|

|                         |                |       |         |
|-------------------------|----------------|-------|---------|
| Birth date (mm/dd/yyyy) | Place of birth |       |         |
|                         | City           | State | Country |

Address

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

Country

|                          |                        |                         |
|--------------------------|------------------------|-------------------------|
| Phone (enter 10 digit #) | Fax (enter 10 digit #) | Cell (enter 10 digit #) |
|--------------------------|------------------------|-------------------------|

Email address

Mailing address if different from above address of record

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

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. Other License, Certification, or Registration

| State/Jurisdiction | Profession | Credential |        |             | Method of Credentialing | Currently In Force |     |
|--------------------|------------|------------|--------|-------------|-------------------------|--------------------|-----|
|                    |            | Type       | Number | Year Issued |                         | No                 | Yes |
|                    |            |            |        |             |                         |                    |     |
|                    |            |            |        |             |                         |                    |     |
|                    |            |            |        |             |                         |                    |     |
|                    |            |            |        |             |                         |                    |     |

## 3. Professional Experience

| Type of experience of practice and location | Start (mm/yyyy) | End (mm/yyyy) |
|---|-----------------|---------------|
|   |                 |               |
|   |                 |               |
|   |                 |               |
|   |                 |               |
|   |                 |               |

## 4. AIDS Education and Training Attestation

I certify I have completed the minimum of four 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 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

## 5. Disciplinary Action Attestation

I certify no action has been taken by any state or federal jurisdiction or hospital, which would prevent or restrict my right to practice my profession.

I further certify I have not voluntarily given up any credential or privilege or have not been restricted in the practice of my profession in lieu of or to avoid formal action.

APPLICANT'S INITIALS

## 6. Continuing Education/Continuing Competency Attestation (If Applicable)

I hereby certify that I have met all continuing education (CE) and competency requirements which I will document upon request.

APPLICANT'S INITIALS

Number of CE hours \_\_\_\_\_

## 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 \_\_\_\_\_  
(Signature of applicant)

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Dental Hygiene Credentialing  
 P.O. Box 47877  
 Olympia, WA 98504-7877  
 360-236-4700

## Dental Hygiene Education Verification

Note: this form must be submitted directly from the Dental Hygiene program.

### Applicant Information:

|            |        |          |               |
|------------|--------|----------|---------------|
| Name First | Middle | Last     | Date of Birth |
| Address    |        |          |               |
| City       | State  | Zip Code |               |

### To be completed by the dental hygiene program:

The student listed above has graduated or successfully demonstrated the following at

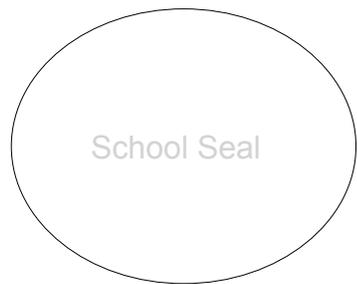
\_\_\_\_\_ on \_\_\_\_\_  
Name of program (mm/dd/yyyy)

which is a dental hygiene program accredited or approved by the following:

- Expanded functions education program approved by the Secretary of the Department of Health.
- The American Dental Association Commission on Dental Accreditation for dental hygiene.
- The Commission on Dental Accreditation of Canada (CDAC) for dental hygiene.

Please check the answers applicable to this student. Please note clinical competency means on live patients.

- |                          |                          |   |
|--------------------------|--------------------------|---|
| Yes                      | No                       |   |
| <input type="checkbox"/> | <input type="checkbox"/> | a. Didactic and clinical competency in the administration of injections of local anesthetic, which includes infiltration: ASA, MSA, Nasopalatine, greater palatine. Block: Long buccal, mental, inferior alveolar, and PSA; |
| <input type="checkbox"/> | <input type="checkbox"/> | b. Didactic and clinical competency in the administration of nitrous oxide analgesia;   |
| <input type="checkbox"/> | <input type="checkbox"/> | c. Didactic and clinical competency in the placement of restorations into cavities prepared by a dentist; and   |
| <input type="checkbox"/> | <input type="checkbox"/> | d. Didactic and clinical competency in the carving, contouring, and adjusting contacts and occlusions of restorations.  |



\_\_\_\_\_  
 Program Director Name (Please print)

\_\_\_\_\_  
 Signature of Program Director

\_\_\_\_\_  
 Date

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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](#)

[Dental Hygienist Laws, RCW 18.29](#)

[Dental Hygienist Rules, WAC 246-815](#)

[Dentistry Laws, RCW 18.32](#)

### **On-Line**

[AIDS Training Resources, Reference Page](#)

[Dental Hygiene Examining Committee Web page](#)