



Dentistry License Without Examination (LWOE) Application Packet

Contents:

- 1. 646-134 Contents List/SSN Information/Mailing Information 1 page
- 2. 646-146 Application Instructions Checklist3 pages
- 3. 646-135 Licenses Requirements2 pages
- 4. 646-160 Dentistry License Without Examination (LWOE) Application ..5 pages
- 5. 646-023 Out-of-State Credential Verification2 pages
- 6. 646-129 DEA Authorization..... 1 page
- 7. 646-125 Location of Practice 1 page
- 8. RCW/WAC and Online Website Links..... 1 page

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 Quality Assurance Commission
Credentialing
P.O. Box 47877
Olympia, WA 98504-7877

Contact us:

360-236-4700

(This page intentionally left blank.)

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.

Complete this application if you:

- Hold an active dentist license in another U.S. State or territory; and
- Are currently engaged in the practice of dentistry. See [WAC 246-817-135](#).

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 the month, day and year of your birth.

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

Address: List the address we should use to send any information on 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. 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. Training and Experience:

List in date order all of your professional education and experience including college or university pre-dental program, technical or professional school and practice pertaining to the profession for which you are making application. Include all periods of time from the date of graduation from dental school to present whether or not engaged in activities related to dentistry. You do not have to list continuing education courses. Attach additional pages if you need more space.

4. Malpractice Insurance:

Indicate if you have malpractice insurance or if coverage is provided via an umbrella policy through a school, or if you are practicing in the military.

5. DEA:

List your DEA # if you have one.

6. 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.

7. AIDS Education and Training Attestation:

Read the AIDS affidavit 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.

8. Applicant's Photograph:

Attach a current photograph in the box provided or attach it to the application. Indicate date the photograph was taken and sign in ink across the bottom of the photo. The photograph must be a clear, close up and a front view. Your application will not be processed without a current photograph.

9. 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](#).

(This page intentionally left blank.)

License Requirements

Thank you for applying to become a licensed dentist in Washington State.

Submit this application if:

- You hold a dentist credential in another U.S. State or territory; and
- You are currently engaged in the practice of dentistry. See [WAC 246-817-135](#).

Please submit the following:

Complete application and [fees](#).

Education:

Provide proof of graduation from an approved dental school.

See [WAC 246-817-110\(2\)\(a\)](#).

Acceptable proof is official transcripts, posted with a dental degree from a Commission on Dental Accreditation (CODA) dental school, and must include a date of graduation. Send transcripts to the Department directly from your dental school. Non-posted transcripts or student copies are not acceptable.

Graduates from a non approved dental school must meet the requirements under [RCW 18.32.215](#) which requires graduates of non-CODA accredited schools to complete a CODA accredited one-year postdoctoral residency and hold an active dentist license in another state for at least four years if applying by license without examination.

Other License, Certification, or Registrations:

Credential verifications must be requested by the applicant and submitted directly from each state credentials are or were held.

Note: Many states charge a verification processing fee. Contact them prior to request to prevent delays in processing.

Proof of Practice:

Complete the [Proof of Practice form](#), which includes, address at your practice location(s), length of time at the location(s) and federal or state tax numbers.

- If you are a dentist serving in the United States federal services (see [RCW 18.32.030\(2\)](#)), submit a letter from the commanding officer outlining duties, length of service and whether any adverse actions have been reported or taken.
- If you are a dentist employed by a dental school (see [WAC 246-817-110\(2\)\(a\)](#)), submit documentation from the dean or the appropriate administrator of the institution regarding the length, terms of employment, responsibilities and any adverse actions or restrictions.
- If you are a dentist in a dental residency program, submit documentation from the director or the appropriate administrator of the residency program regarding the length of the residency, duties and responsibilities and any adverse actions or restrictions.
- If you are a dentist practicing dentistry for a minimum of 20 hours per week for the four consecutive years preceding this application in another U.S. state or territory, complete the [proof of practice form](#).

Malpractice Insurance

Applicants must have all malpractice carriers submit a letter verifying dates of coverage and any claims history. In the event of a claims history, appropriate legal documentation must also be submitted. If coverage is provided via an umbrella policy through a school, or if you are practicing in the military, please indicate in writing.

DEA

Complete this [form](#) if you have ever had a DEA number and submit it directly to the Drug Enforcement Administration in Seattle. To contact the Seattle DEA, call 1-888-219-1418. If you have not had a DEA number please complete the attestation on the application.

- Completion of the [on-line Jurisprudence Examination](#). Once you have successfully completed the examination, your electronic results will be submitted to the Department. Please print the results page for your records. It is a multiple choice exam and designed to familiarize you with the Washington State dentistry laws. Current laws can be found on our [website](#).

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 address of record is kept up to date. Any renewal postmarked or presented to the department after midnight on the expiration date is late.

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

Note: You cannot practice dentistry until your license is issued.

Date
Stamp
Here

Rev 0251030000

Dentistry License Without Examination (LWOE) Application

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

1. Demographic Information

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

Dental school

DEA # (if applicable)

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. Training and Experience

List in date order all of your professional education and experience including college or university pre-dental program, technical or professional school and practice pertaining to the profession for which you are making application. Include all periods of time from the date of graduation from dental school to present whether or not engaged in activities related to dentistry. You do not have to list continuing education courses. Attach additional pages if you need more space.

Dates		Name and address of institute, place of practice.	Degree/certificate and date received Type of experience or specialty
From (mm/dd/yyyy)	To (mm/dd/yyyy)		

4. Malpractice Insurance

Do you have Malpractice Coverage? Yes No

Please provide the name of your malpractice insurance carrier: _____

If yes, have your malpractice carrier submit a letter verifying dates of coverage and any claims history. In the event of a claims history, appropriate legal documentation must also be submitted.

Is your coverage provided via an umbrella policy through a school? Yes No

Is your coverage provided via the military? Yes No

If your coverage is via an umbrella policy through a school or provided by the military, please indicate that by attesting.

Applicant's Initials	Date
----------------------	------

5. DEA

Do you have a DEA number? Yes No

If yes, list your DEA number and submit the [DEA Authorization form](#).

DEA # _____

If no, please indicate that by attesting.

I certify that I have never obtained a DEA number.

Applicant's Initials	Date
----------------------	------

6. 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	Profession	Certificate		Permanent or Temporary	License received by		Currently in force
		Year issued	Number		Examination	Other	
				<input type="checkbox"/> Perm <input type="checkbox"/> Temp			<input type="checkbox"/> No <input type="checkbox"/> Yes
				<input type="checkbox"/> Perm <input type="checkbox"/> Temp			<input type="checkbox"/> No <input type="checkbox"/> Yes
				<input type="checkbox"/> Perm <input type="checkbox"/> Temp			<input type="checkbox"/> No <input type="checkbox"/> Yes
				<input type="checkbox"/> Perm <input type="checkbox"/> Temp			<input type="checkbox"/> No <input type="checkbox"/> Yes
				<input type="checkbox"/> Perm <input type="checkbox"/> Temp			<input type="checkbox"/> No <input type="checkbox"/> Yes
				<input type="checkbox"/> Perm <input type="checkbox"/> Temp			<input type="checkbox"/> No <input type="checkbox"/> Yes

7. 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	Today's Date
----------------------	--------------

8. Applicant's Photograph

Photo Here



Attach Current Photograph Here.
Indicate Date Taken and Sign in Ink Across Bottom of the Photo.
NOTE: Photograph **Must** Be:

1. Original, not a photocopy
2. No larger than 2" X 2"
3. Taken within one year of application
4. Close up, front view—not profile
5. Instant Polaroid Photographs **not** acceptable

9. 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 that 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.

By: _____ Date _____
(Signature of applicant) (mm/dd/yyyy)

(This page intentionally left blank.)



Washington State Department of

Health

Dental Quality Assurance

Commission

Credentialing

PO 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. Instruct them to return the form directly to the above address. 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:		
License, Certification, or Registration Number	Date Issued	

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

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 & title)		
Applicant licensed, certified, registered by: Written Examination	Date:	Score:
Name of examination:		
Other Examination	Date:	Score:
Name of examination:		
Is it current? Yes <input type="checkbox"/> No <input type="checkbox"/>	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.		
Have they 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 individual 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: _____

(SEAL)

Title: _____

Date: _____



Washington State Department of
Health
 Dental Quality Assurance Commission
 Credentialing
 PO Box 47877
 Olympia, WA 98504-7877
 360-236-4700

DEA Authorization

To the Applicant: Fill out this form if licensed in another state.

Please complete the identifying information and submit this form directly to:

Drug Enforcement Administration
 Attention: Diversion Unit, Registration
 300 5th Ave Ste 1300
 Seattle, WA 98104

Date: _____

To Whom It May Concern:

I am applying for a license to practice dentistry in the state of Washington. Please send this form directly to the Dental Quality Assurance Commission Credentialing.

Applicant Printed Name: _____

Date of birth: _____

DEA Registration Number: _____

DEA Registration Number: _____

DEA Registration Number: _____

DEA Registration Number: _____

If you have additional DEA Registration Numbers, please attach another form.

Applicant's signature _____

To be completed by the Drug Enforcement Administration:

Applicant has surrendered (for cause) or had a federal controlled substance registration revoked, suspended, restricted, or denied. Yes No

Initials _____ Date _____

Please mail this completed form to the Dental Quality Assurance Commission Credentialing Section at the address listed above, or you can email it to:

hsqlacredialreview@doh.wa.gov.

(This page intentionally left blank.)



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

Proof of Practice

Demographics:		
Name First	Middle	Last
Washington Credential #, if applicable	Date of Birth	
Address		
City	State	Zip Code
Location of Practice:		
If you have been at the location listed for less than four years, attach an additional sheet of paper, listing other practice locations.		
<input type="checkbox"/> I certify that I am in the practice of dentistry at the following location, I further certify I have practiced dentistry, as defined in RCW 18.32.020 , for at least a minimum of twenty hours per week for the four years proceeding this application in another U.S. State or territory.		
Address: _____		
City: _____ State: _____ Zip Code: _____		
From _____ to _____ (mm/yyyy) (mm/yyyy)		
Federal Tax No. _____ State Tax No. _____		
<input type="checkbox"/> I certify that I am a dentist serving in the United States federal services. I will submit a letter from my commanding officer outlining my duties, length of service and whether any adverse actions have been reported or taken.		
<input type="checkbox"/> I certify that I am a dentist employed by a dental school, I will submit documentation from the dean or the appropriate administrator of the institution regarding the length, terms of employment, responsibilities and any adverse actions or restrictions.		
<input type="checkbox"/> I certify that I am a dentist in a dental residency program, I will submit documentation from the director or the appropriate administrator of the residency program regarding the length of the residency, duties and responsibilities and any adverse actions or restrictions.		
Applicant's Signature _____ Date _____		

(This page intentionally left blank.)



RCW/WAC and Online Web Site Links

RCW/WAC Links

[Uniform Disciplinary Act, RCW 18.130](#)

[Administrative Procedure Act, RCW 34.05](#)

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

[Standard of Professional Conduct Rules, WAC 246-16](#)

[Dental Professionals Laws, RCW 18.260](#)

[Dentistry Rules, WAC 246-817](#)

[Dentistry Laws, RCW 18.32](#)

On-Line

[AIDS Training Resources, Reference Page](#)

[Dental Quality Assurance Commission, Web page](#)

[Drug Enforcement Administration \(DEA\), \[www.deadiversion.usdoj.gov\]\(http://www.deadiversion.usdoj.gov\)](#)

[Washington State Dental Association, \[www.wsda.org/\]\(http://www.wsda.org/\)](#)

[American Dental Association \(ADA\), \[www.ada.org/\]\(http://www.ada.org/\)](#)

Listserv

To receive emails regarding important dental regulation information, please join our interested parties list at, [Listserv](#)

Required Continuing Education

Continuing education (CE) Training after license has been issued, [WAC 246-817-440](#)