Denturist License Application Packet

Contents:
1. 643-007 .... Contents List/SSN Information/ Mailing Information ......................... 1 page
2. 643-012 .... Application Instructions Checklist .......................................................... 3 pages
3. 643-006 .... License Requirements ........................................................................ 2 pages
4. 643-001 .... Denturist License Application .............................................................. 5 pages
5. 643-008 .... Written Exam Blueprint ...................................................................... 1 page
6. 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:
Board of Denturists Credentialing
P.O. Box 47877
Olympia, WA 98504-7877

Contact us:
360-236-4700
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.

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.
- If you have been granted certificate(s) of restoration of opportunity, please provide a certified copy of each certificate.
- 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, including Washington, where credentials are or were held. Attach additional completed pages if you need more space. You must also print the Verification Form and provide it to each state or jurisdiction that you have listed, requesting that they complete and submit the form directly to the Department of Health.

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.
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 you completed a Washington board approved denturist program and were licensed prior to July 1, 2012 or;
     - If you completed a Washington board approved denturist program, completed the Denturist Qualifying Examinations administered by the Denturist Examination Group and were licensed after February 23, 2018.
   - Montana
     - If you completed a Washington board approved denturist program, completed the Denturist Qualifying Examinations administered by the Denturist Examination Group and were licensed after February 23, 2018.
   - Oregon
     - If you 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 and 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. It is a multiple-choice examination, designed to familiarize you with the Washington State denturity 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.

Information regarding the denturist program is also available on our website.

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

Social Security Number (SSN)  National Provider Identifier Number (NPI)
(If you do not have a SSN, see instructions)  (Enter 10 digit number)

☐ Male  ☐ Female

Name
First  Middle  Last

Birth date (mm/dd/yyyy)

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):
### Personal Data Questions

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.

   If you have been granted certificate(s) of restoration of opportunity, please provide a certified copy of each certificate.

   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.
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.

<table>
<thead>
<tr>
<th>Schools Attended</th>
<th>Degree Earned</th>
<th>Attendance Dates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full Name, City and State</td>
<td></td>
<td>Start (mm/yyyy)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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.

<table>
<thead>
<tr>
<th>Name of Business</th>
<th>Total Number of Months</th>
<th>Dates</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Start (mm/yyyy)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>State Jurisdiction</th>
<th>License Number</th>
<th>License Issue Date</th>
<th>Expiration Date</th>
<th>Method of License</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Applicant's Initials</th>
<th>Date</th>
</tr>
</thead>
</table>
7. Applicant’s Attestation

I, ________________________________________, declare under penalty of perjury under the laws of 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)
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%
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