Dental Hygiene Initial Limited License Application Packet

Contents:
1. 645-155...Contents List/SSN Information/Mailing Information................................. 1 page
2. 645-146...Application Instructions Checklist.................................................................3 pages
3. 645-157...License Requirements.................................................................................. 2 pages
4. 645-138...Dental Hygiene Initial Limited License Application......................................5 pages
5. 645-117....Expanded Functions Education Information.............................................. 1 page
6. 645-163...Education Verification Local Anesthesia Endorsement ............................. 1 page
7. DANB.......Dental Hygiene Law Examination Fact Sheet, Law Exam
Application, Application Agreement, and Special
Accommodations Form .................................................................................................. 10 pages
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 Hygiene Credentialing
P.O. Box 47877
Olympia, WA 98504-7877

Contact us:
360-236-4700

DOH 645-155 September 2018
Application Instructions Checklist

You should complete this application to obtain an initial limited dental hygiene license if you have a license in another state or Canadian province with a similar scope of practice to the dental hygiene scope of practice in Washington State. To qualify for licensure you must meet the following requirements:

• Currently hold an active license in another state or Canadian province.
• Be actively practicing in another state or Canadian province. Actively practicing means that you have worked at least 560 hours within the preceding 24 months.
• Graduated from a CODA accredited dental hygiene program.
• Successfully completed the Dental Hygiene National Board Examination.
• Successfully completed the Washington State Drug and Law Jurisprudence Examination.
• Completed an approved 7 hour HIV/AIDS education program.

The following states are not equivalent to Washington State’s scope of practice:

• Delaware
• Kentucky
• New York

The initial limited license is valid for 18 months from the date that credential was issued. In order to renew, you must provide proof of successful completion of the following items:

• An approved dental hygiene patient evaluation/prophylaxis examination.
• An approved local anesthesia examination.
• Demonstration of didactic and clinical competency in the administration of nitrous oxide analgesia.

Note: It is recommended that you submit the renewal application, renewal fee and appropriate expanded functions verification documentation at least 90 days before your initial limited license expiration date.

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.

☐ 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 the month, day and year of birth.

**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.

- 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, most recent to later, the professional education, including pre-dental hygiene received for a degree in dental hygiene. All periods of time from graduation date to present must be listed whether or not engaged in activities.
related to the practice of dental hygiene. Continuing education courses do not need to be listed. Attach additional pages if you need more space.

**Transcripts:** Graduation from an American Dental Association Commission on Dental Accreditation (CODA) dental hygiene education program is the approved education for license. Have your school send official school transcripts directly to the Dental Hygiene Program.

☐ **4. Experience:**
List in date order, most recent to later, your dental hygiene work experience from date of graduation to present. Attach additional pages if you need more space.

☐ **5. Examination:**
Check all the dental hygiene examinations you have taken. The following examinations are the required examinations for initial limited license.

- Dental Hygiene National Board exam and the Washington State Drug and Law exam administered by Dental Assisting National Board, Inc.

☐ **6. Other License, Certification, or Registration:**
List all states, including Washington, where credentials are or were held. 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. 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.

☐ **7. 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.

☐ **8. 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.
License Requirements

The following will only be accepted when received by the department directly from the source. These items should not be included with your application.

  • A minimum score of 90 percent is required.
  • Dental hygiene laws and rules are located in **RCW 18.29** and **WAC 246-815**.
  • Dental laws and rules are located in **RCW 18.32** and **WAC 246-817**.

Dental Assisting National Board, Inc. gives the exam. An application to apply for this exam is enclosed.

☐ Official dental hygiene school transcripts showing degree and date degree was conferred. The program must be currently accredited or received initial accreditation by the American Dental Association Commission on Dental Accreditation (CODA) on or before June 30, 2007 or from the Commission on Dental Accreditation of Canada (CDAC).

☐ Verification of your passing Dental Hygiene National Board Examination. To obtain verification of your exam scores contact:

Joint Commission on National Dental Hygiene Examinations
211 East Chicago Avenue, Suite 660
Chicago, Illinois 60611-2637
1-800-232-1694

☐ License certification form. A verification/certification from any state or Canadian province you have been credentialed in must be sent directly to the Dental Hygiene Program. 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.

**Note:** The initial limited license allows for the following scope of practice:

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 and stains 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.
j. Performing root planing.
Initial Limited license holders are **not** allowed to perform the following procedures:

- Restorative dentistry.
- Administration of local anesthetic.
- Administration of nitrous oxide analgesia.

Upon successful completion of an approved dental hygiene expanded functions local anesthesia examination, an applicant may request that the department add a local anesthesia endorsement to their credential.

**Note:** Administration of nitrous oxide analgesia is not included with the local anesthesia endorsement. Nitrous oxide administration is only allowed with a renewable limited license or a full dental hygiene credential.

### Other Information

Thank you for applying for the initial limited dental hygienist license in Washington State. The 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 limited license will expire 18 months from the date of initial issue. When renewed, the limited license will expire on your birthday unless the renewal 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.
- Information regarding the dental hygiene program is available on our [website](#).

**Note:** You cannot practice dental hygiene until your license is issued.
# Dental Hygiene Initial Limited License Application

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

- Initial Limited License
- Anesthetic Endorsement

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

## 1. Demographic Information

<table>
<thead>
<tr>
<th>Social Security Number (SSN)</th>
<th>National Provider Identifier Number (NPI)</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>(If you do not have a SSN, see instructions)</td>
<td>(Enter 10 digit number)</td>
<td>☐</td>
<td>☒</td>
</tr>
</tbody>
</table>

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):
2. 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, most recent to later, your educational preparation. Attach additional 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</td>
<td></td>
<td>Start (mm/yyyy)</td>
</tr>
<tr>
<td>and State</td>
<td></td>
<td>End (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>
</tbody>
</table>

4. Experience

I certify I hold an active license. I am currently in practice and have 560 hours of practice in the preceding
24 months.

<table>
<thead>
<tr>
<th>Dates From (mm/dd/yyyy)</th>
<th># Hours per week</th>
<th>Name and address of place of practice</th>
<th>Type of experience or specialty</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
5. Examination

The examinations listed below are the approved examinations for licensure. Check all that you have taken.

☐ Dental Hygiene National Board examination.
  Date of exam: __________________________
  (mm/dd/yyyy)

☐ Washington State Drug and Law exam (administered by Dental Assisting National Board, Inc.).
  Date of exam: __________________________
  (mm/dd/yyyy)

  Date of exam: __________________________
  (mm/dd/yyyy)

☐ CRDTS Patient Evaluation/Prophylaxis if passed after November 1, 2001.
  Date of exam: __________________________
  (mm/dd/yyyy)

  Date of exam: __________________________
  (mm/dd/yyyy)

  Date of exam: __________________________
  (mm/dd/yyyy)

☐ WREB Restorative examination if passed after May 8, 1992.
  Date of exam: __________________________
  (mm/dd/yyyy)

☐ CRDTS Anesthesia examination if passed after October 13, 2017.
  Date of exam: __________________________
  (mm/dd/yyyy)

☐ CRDTS Restorative examination if passed after March 7, 2016.
  Date of exam: __________________________
  (mm/dd/yyyy)

6. Other License, Certification or Registration

List all states, including Washington and Canadian provinces, where credentials are or were held. Attach additional completed pages if you need more space.

<table>
<thead>
<tr>
<th>State</th>
<th>Profession</th>
<th>Certificate</th>
<th>Permanent or Temporary</th>
<th>Currently in force</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Year issued</td>
<td>Number</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>
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 if 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>

8. 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: __________________________
(Signature of applicant)
Dental Hygiene Expanded Functions

Education Information

Applicants interested in taking approved expanded function courses in preparation for Washington State Dental Hygiene License, may contact the schools listed below for courses and availability which may include local anesthetic, nitrous oxide/oxygen analgesia and restorative dentistry.

Pierce College
Fort Steilacoom
Lakewood, WA
Contact Phone—253-964-6248
Contact email—vm-dentalinstitute@pierce.ctc.edu
www.pierce.ctc.edu
Anesthetic, Nitrous Oxide and Restorative

Lake Washington Institute of Technology
Kirkland, WA
Contact the Dental Hygiene Department: Beth Davis at 425-739-8386 or Monta Frost, Director at 425-739-8404
Anesthetic and Nitrous Oxide

Eastern Washington University
Cheney, WA
Contact Phone—509-828-1300
Contact email—awetmore@ewu.edu
www.ewu.edu
Restorative

Phoenix College
Phoenix, AZ
Contact Nan Reif, Director, Center for Health Professions 602-285-7331
Anesthetic and Nitrous Oxide

Oregon Health & Science University
Portland, OR
Contact Debbie Reaume, Continuing Education Program 503-494-8857
Nitrous Oxide

Portland Community College
Institute for Health Professionals
Portland, OR
Contact Stacy Bone 971-722-6629
Contact email—stacy.bone@pcc.edu
www.pcc.edu/climb/health
Restorative

HIV/AIDS Education Information

Dental Hygienists must complete seven hours of HIV/AIDS education prior to obtaining their license. Information on approved courses can be found on Department of Health Online Resources Page.
(This page intentionally left blank.)
Dental Hygiene Expanded Functions
Education Verification Local Anesthesia Endorsement Form

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

### Applicant Information:

<table>
<thead>
<tr>
<th>Name</th>
<th>First</th>
<th>Middle</th>
<th>Last</th>
<th>Date of Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Address</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

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

__________________________ on __________________________ (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.

☐ Other, please list: ________________________________________________________

Please note clinical competency means on live patients.

Did the student complete 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?

☐ Yes  ☐ No

Program Director Name (Please print)

__________________________________________

Signature of Program Director

__________________________________________

Date