MINNESOTA BOARD OF DENTISTRY

University Park Plaza, 2829 University Avenue SE, Suite 450
Minneapolis, MN 55414-3249 www.dentalboard.state.mn.us
Phone 612.617.2250 Fax 612.617.2260
Toll Free 888.240.4762 (non-metro)
MN Relay Service for Hearing Impaired 800.627.3529

Dear Hygienist;

We are enclosing the application form that you requested for licensure by credentials in Minnesota. The requirements for licensure by credentials are outlined on page 6 of the application. Please review them carefully and feel free to call the Board office with any questions.

Upon receipt of your completed application, we will send reference forms to each person listed as a reference on your application. Please contact your references to request their immediate attention and return of the reference form to the Board office. Your application will not be considered complete and an interview will not be scheduled until all reference forms have been returned to this office.

The Credentials Committee of the Board meets approximately every six weeks. There is a need to limit the number of interviews scheduled at each credential meeting, due to various time constraints. Interviews are scheduled on a first-come, first-served basis as applications are completed.

Applicants for licensure by credentials shall be given an oral examination (interview) by the Credentials Committee and must satisfactorily respond to questions designed to determine the applicant's knowledge of dental subjects and ability to practice dentistry pursuant to Minnesota Statutes 150A.06, subdivision 4. As you prepare for your interview, please consider that the purpose of the Board is to protect the public. The questions you will be asked are based on the core subject areas of infection control, patient communication, ethics, record keeping, management of medical emergencies and diagnosis and treatment planning. You will be notified about 20 days before the date of your interview. If the interview as scheduled is not convenient for you, we will schedule you for the next Credentials Committee meeting.

Please feel free to contact me if you have any questions about licensure by credentials or the Jurisprudence Examination.

Joyce Nelson
Licensing Supervisor
(612) 548-2129
joyce.nelson@state.mn.us

Enclosures

Lic # ___________________
Issued ___________________
App # ___________________

MINNESOTA BOARD OF DENTISTRY

2829 University Avenue SE, Suite 450
Minneapolis, Minnesota 55414
(612) 617-2250 (888) 240-4762
MN Relay Operator for Hearing and Speech Impaired
(800) 627-3529

APPLICATION FOR LICENSURE BY CREDENTIALS TO PRACTICE DENTAL HYGIENE

(Requirements listed on page 6 of application)

NON REFUNDABLE FEE DUE - $269.75

(Application Fee $175.00; Background Check Fee $34.75; Initial Fee $60.00)

Instructions. This application is to be completed by dental hygienists applying for licensure by credentials as authorized by Minnesota Statutes §150A.06, Subd. 4 and Minnesota Board of Dentistry Rule 3100.1400. Each item on this application must be answered fully, truthfully, and accurately by the applicant. Fraud or deception in securing a license is a gross misdemeanor and cause for revocation or suspension of a license. If space for any answer is insufficient, the answer may be completed on another piece of paper. Please specify the number of the item, sign it, and attach it to the rest of the application. BE SURE ALL FOUR PAGES OF THIS APPLICATION AND ITS ATTACHMENTS ARE COMPLETED.

Minnesota Government Data Practice Act Notice. This notice is given pursuant to Minnesota Statutes §13.04, subdivision 2, and §13.41, subdivision 2. In order to be licensed, you must submit all the information requested in this application. The Board will use the information to determine if you meet statutory and rule requirements for licensure. Accordingly, OMISSIONS OR INACCURACIES ARE GROUNDS FOR DENYING YOUR APPLICATION. All data, except your name and address, submitted by you or on your behalf are considered private until you are licensed, at which point the data becomes public. “Private” is defined by law as information which is accessible only to: you; the staff and members of the Board; the Board’s legal counsel; any person to whom the Board must refer the application or parts thereof for verification purposes or for otherwise determining your qualifications; and to persons you designate. In addition, if the matter of your license becomes contested and thereby results either in a contested case hearing or litigation, the data submitted by you or on your behalf may also become accessible to the Minnesota Office of Administrative Hearings, appropriate courts, and those associated with such proceedings, and thereby become public data.

Americans With Disabilities Act. It is the policy of the Minnesota Board of Dentistry to comply with the Americans With Disabilities Act (ADA). The ADA provides, in part, that qualified individuals with disabilities shall not be excluded from participating in or be denied the benefits of any program, service, or activity offered by the Minnesota Board of Dentistry. If you require additional information about the Minnesota Board of Dentistry’s ADA policy please contact the Minnesota Board of Dentistry’s designated ADA coordinator.

*****THIS APPLICATION WILL BE COPIED FOR REVIEW - PLEASE TYPE OR PRINT LEGIBLY IN BLACK INK*****

BACKGROUND

1.	Name (last, first, middle)		Today’s Date
2a.	Mailing Address (street)	City, State, Zip	
2b.	Primary Practice Address (street) (required if employed)	City, State, Zip	
3.	Telephone (include area code) ( )	Email Address (mandatory)	
4.	Sex ❑ Male ❑ Female	Birth date	Social Security No. __________--__________--__________
5.	Other name(s) by which you are or have been known and reasons for change		

DENTAL HYGIENE EDUCATION

6.	Dental Hygiene School

7.	Location	Date of Graduation (month, day, year)
8.	Degree (attach one of the following: notarized copy of diploma, OR original official transcript, OR original certificate/letter of graduation): ❑ A.S. ❑ A.A.S. ❑ B.S. ❑ Other (specify) ________________	
9.	Other College or University Education (include dates and degrees earned)	

EXAMINATIONS

	Month	Day	Year
10. NATIONAL BOARD EXAMINATION - Date Completed **(Attach a notarized copy of National Board certificate or card)**			
11. CLINICAL EXAMINATION FOR LICENSURE – Date Completed **(Attach a notarized copy of letter or certificate. Canadian applicants should submit a notarized copy of their National Dental Examining Board of Canada certificate)**			
12. MINNESOTA JURISPRUDENCE EXAMINATION - Date Completed **(Attach an original or notarized copy of the Exam results. Examination on the Rules of the Minnesota Dental Practice Act must be passed within 5 years prior to application.)**			

13. Other national, regional, state, or Canadian Province licensure examinations (give names and dates of each examination and indicate any failures.)

PROFESSIONAL BACKGROUND

14. List each state, Canadian Province and country where you currently or have previously held a license as a dental hygienist or licensed/registered dental assistant: ____

15.

AFFIDAVIT OF LICENSURE

This Affidavit of Licensure, copy thereof, or official letter must be completed by the licensing authority of each state, province and country listed in item 14. The original document, containing an official signature and seal, must be submitted.

I, ______________________________________ Secretary/Chair of the ___________________________________

____ hereby certify that ______________________________________

was granted license number ______________ to practice dental hygiene in __________________________________

on the ______ day of ________________, ________, and that this license is: ❑ active ❑ terminated ___________.
(year)

I further certify that disciplinary action: ❑ has been taken against said licensee* ❑ has not been taken against said licensee; **AND**

❑ is pending* ❑ is not pending ❑ that pending disciplinary action cannot be confirmed or denied.

Dated this _______ day of ________________, 20_______.

(SEAL)

Signed ____
(Signature of Secretary or Chair)

Title ____

**Please attach a statement pertaining to disciplinary action, if any.*

DISCLOSURE QUESTIONS

		YES	NO
16.	Have you ever been denied a license to practice dental hygiene in another state or Canadian Province? (*If so, attach a statement indicating the location, date and reason for such denial.)*	❑	❑
17.	Have you ever been suspended from practice, reprimanded, censured or otherwise disciplined or disqualified as a dental hygienist or other professional? (*If so, attach a statement indicating reason for action, dates, disposition and address of licensing authority in possession of record.)*	❑	❑
18.	Do you have any criminal charges pending against you? *(If so, attach a statement giving full details including reason, dates, name and location of court, and case number.)*	❑	❑
19.	Have you ever been convicted of a felony, gross misdemeanor or misdemeanor? *(If so, attach a statement giving full details including reason, dates, name and location of court, and case number.)*	❑	❑
20.	Are there any unsatisfied judgments against you that resulted from the practice of dental hygiene? *(If so, attach a statement giving details including nature of judgment, dates and reasons for non-payment.)*	❑	❑
21.	Based on your assessment or that of another professional, does your use of alcohol or drugs, or the existence of a physiological or psychological medical condition, in any way impair or limit your ability to practice dental hygiene with reasonable skill and safety?	❑	❑

If yes, please 1) explain the use or medical condition, and 2) explain whether the impairment(s) or limitation(s) caused by your use of alcohol or drugs or by the existence of your physiological or psychological medical condition are reduced or ameliorated because you receive ongoing treatment or because of the manner in which you have chosen to practice . *(Please provide these explanations on a separate attachment to your application.)*

		YES	NO
22.	Are you a member of a dental hygiene association or society? (If so, give names and locations). ________	❑	❑

____

23. EMPLOYMENT – Professional (Active practice of 2,000 hours within the last 36 months)

	(1)	(2)	(3)
Name of Practice			
Address			
Dates (from-to)			
Supervisor			
Duties			
# of Hours week			
Reason for leaving			

24. EMPLOYMENT – Other (Since graduation from dental hygiene school)

Name of Practice			
Address			
Dates (from-to)			
Supervisor			
Duties			
# of Hours week			
Reason for leaving			

25. Reasons for applying for licensure in Minnesota: ____

____

TESTIMONIALS AND REFERENCES:

- **You must provide two testimonials and two references with your application.**
- **Your testimonials and references must include two dentists and two dental hygienists with whom you are acquainted (for at least one year) but not related to and are not included elsewhere on this application.**

TESTIMONIALS

26. This certifies that I have been personally acquainted with ____ for _________years, that I know him/her to be of good professional character and hereby recommend him/her to the Minnesota Board of Dentistry for licensure to practice dental hygiene in Minnesota.

    Name ____Address ____

    City ________________________________ State ___________ Zip ________________ Phone # ________________________

    ❑ Dental or ❑ dental hygiene school graduated from ________________________________ on ________/________/________

    Licensed in (state or province) ____License Number ________________________

    ____
    (Original Signature) *(Date)*

27. This certifies that I have been personally acquainted with ____ for _________years, that I know him/her to be of good professional character and hereby recommend him/her to the Minnesota Board of Dentistry for licensure to practice dental hygiene in Minnesota.

    Name ____Address ____

    City ________________________________ State ___________ Zip ________________ Phone # ________________________

    ❑ Dental or ❑ dental hygiene school graduated from ________________________________ on ________/________/________

    Licensed in (state or province) ____License Number ________________________

    ____
    (Original Signature) *(Date)*

REFERENCES

28. Name ____ Occupation _________________________

    Address ____

    City ____ State __________ Zip ____________________

    Phone # ____ Email:____

29. Name ____ Occupation _________________________

    Address ____

    City ____ State __________ Zip ____________________

    Phone # ____ Email:____

30. PHOTOGRAPH

For identification purposes, please tape one passport size photograph here taken within the last 6 months

REMINDERS

	YES	NO
Is the required statement from a licensed physician attesting to your physical and mental condition attached *(physical exam must have been completed within the previous 12 months)* (Attachment A)?	❑	❑
Is the required statement from a licensed ophthalmologist or optometrist attesting to your visual acuity attached *(vision exam must have been completed within the previous 12 months)* (Attachment B)?	❑	❑
Is attachment C completed with continuing dental education courses taken in the last five years?	❑	❑

AFFIDAVIT OF APPLICANT

31. STATE OF ____________________)
COUNTY OF __________________) ss.

I, ____, the applicant being first duly sworn, certify that I am the person referred to in this application for dental hygiene licensure, that under penalty of perjury all the information contained in this application and in any attachment or additional document submitted herewith is true and correct and that all persons and organizations, whether public or private, are authorized to release to the Minnesota Board of Dentistry any information, files or records requested in connection with this application.

APPLICANT'S ORIGINAL SIGNATURE ____
(Sign before a Notary Public)

Sworn to before me this _______ day of _______________________, 20 ____

My Commission expires ____ *(SEAL)*

____
Notary Public Signature

REQUIREMENTS FOR LICENSURE BY CREDENTIALS AS A DENTAL HYGIENIST:

A) Be a graduate of a dental hygiene school accredited by the Commission on Accreditation;

B) Hold or have held a license to practice dental hygiene in another state or Canadian Province, in good standing;

C) Have passed a clinical examination for licensure in another state or Canadian Province where the licensure requirements are substantially equivalent to those of Minnesota (Canadian applicants should submit a notarized copy of their National Dental Examining Board of Canada certificate);

D) Have been in active practice in another state, Canadian Province, or United States government service at least 2,000 hours within last 36 months;

E) Submit a physician's statement attesting to the applicant's physical and mental condition *(Physical exam must have been completed within the last 12 months)* (Attachment A);

F) Submit a licensed ophthalmologist's or optometrist's statement attesting to the applicant's visual acuity *(vision exam must have been completed with the last 12 months)* (Attachment B);

G) Submit summary of continuing dental education courses taken in the last five years (Attachment C);

H) Submit the licensure by credential application fee in U.S. Funds. Your check or money order should be payable to the Minnesota Board of Dentistry;

I) Be examined and receive a passing score on an examination covering the Rules of the Board and the Minnesota Dental Practice Act (Minnesota Jurisprudence Examination). *Information on the Jurisprudence Exam may be found at* http://mn.gov/health-licensing-boards/dentistry/licensure/jurisprudence.jsp;

J) Submit a completed application form; **including a photocopy of current BLS Healthcare provider CPR.**

K) Appear before the Credentials Committee of the Board for a personal interview and satisfactorily respond to questions designed to determine your knowledge of dental hygiene subjects and ability to practice dental hygiene pursuant to Minnesota Statutes 150A.06, subdivision 4.

NOTES – PLEASE READ CAREFULLY:

1. Please be sure all FOUR pages of this application are completely answered. Incomplete applications MUST be returned to you without action pursuant to Minnesota Rule 3100.1500.

2. Remember to attach the required original documents or NOTARIZED copies listed in items 8, 10, and 11. *(A notarized copy is a photocopy that is certified to be a true copy of the original document and is signed and stamped/sealed by a notary public.)*

3. The examination on the Rules of the Board and the Minnesota Dental Practice Act (item 12).

4. Your check or money order, in the amount listed on page 1 of this application, should be payable to the **Minnesota Board of Dentistry**. Pursuant to Minnesota Statutes Section 604.113, there will be a $20 service charge on all checks not honored by your bank.

5. Following receipt of the application and verification of the applicant's credentials and references, the applicant will be notified as to the date and location of the personal interview with the Board.

6. Your entire application will be copied for review by our Committee members. Please complete the application and its attachments using black ink, and print or type all information.

If you intend to provide Nitrous Oxide you must fill out the proper application, unless you are a graduate of a Minnesota accredited program after September 2, 2004. Application can be found at:

- Nitrous Oxide: http://mn.gov/boards/assets/Nitrous%20Appl.%20Revised%2010-2015_tcm21-76069.pdf

_ PLEASE DO NOT WRITE BELOW _

____ DIP ____ ____ PR 1 YR ____ ____ PHY STMT ____ ____ REF LTRS
____ NATL ____ ____ PHOTO ____ ____ EYE STMT ____ ____ TESTIM.
____ CLINC ____ ____ FEE ____ ____ CDE LOG ____ ____ OTHER
____ JURIS ____ ____ AFFID. ____

ATTACHMENT A

Application for Licensure by Credentials in Minnesota

REPORT OF EXAMINING PHYSICIAN
Physical Exam must have been completed within the last 12 months

I, ____, a duly licensed physician in

the State of ____ have this

_______________ day of _________________________________, ________________
(month) (year)

Examined ____.
(name of applicant)

My examination reveals that the examinee is not chemically dependent, nor do I find that the examinee has any physical or mental disabilities, except: _______________________

____

____.

This examination was made at ____
(clinic name and address)
____,

the State of ________________________________.

____
Signature of Physician

_______________________________ _______________
Physician Name Credentials/Degree

____
Address

____
City, State, Postal Code

ATTACHMENT B

Application for Licensure by Credentials in Minnesota

EYE EXAMINATION REPORT
Vision exam must have been completed within the last 12 month

____ ___________________
Examinee Date of Examination

This is a summary of the results of the examination of your eyes and vision. Items checked apply to you.

1. Health of eyes:

External: good ________ other ________

Internal: good ________ other ________

2. Recommendations (check one below):

- No lenses needed: ________
- No change in present lenses needed: ________
- New lenses recommended:

Single vision ________
Single vision sunglasses ________
Contact lenses ________
Bifocals ________
Bifocal sunglasses ________
Trifocals________

Additional Comments:
____

____.

____
Signature of Ophthalmologist or Optometrist

____________________________________ _____________
Ophthalmologist or Optometrist Name Credentials/Degree

____
Address

____
City, State, Postal Code

ATTACHMENT C

Application for Licensure by Credentials in Minnesota

Record of Continuing Dental Education Taken within the Past 5 years:

(Please make copies of this page as needed.)

Date of Course	Course Title	Detailed Course Description	Name & credentials of Course Presenter	Hours Attended