



# **BOARD OF DENTISTRY**

## **DENTAL HYGIENE APPLICATION**

**OCTOBER 2007**

**EXAMINATION ADMINISTRATION DATE**

**THIS APPLICATION SHOULD BE USED FOR THE OCTOBER 2007  
DENTAL HYGIENE EXAMINATION ONLY  
DO NOT SUBMIT THIS FORM AFTER AUGUST 1, 2007**

Revised July 2, 2007

**Dental Hygiene Examination Application Instructions**  
**TENTATIVE Examination Dates – October 5-7, 2007**  
**University of Florida, Gainesville**

Pages 1-3 of the application and fee **MUST** be received together and postmarked no later than **AUGUST 1, 2007** for you to be considered an applicant; pages 4-6 and all other credentials must be **RECEIVED** no later than **SEPTEMBER 1, 2007**, except as indicated in these instructions. Failure to appropriately meet these deadlines shall result in you being deemed ineligible to sit for the **OCTOBER 2007 Dental Hygiene Examination**. If an application is received without the fee attached, the application will automatically be returned. A social security number issued by the Federal Government is required for licensure. After completing the application, double check to make sure you have marked all questions as “yes” or “no” or not applicable. Also be sure to sign and date the application. **If you answered, “yes” to question(s) 5A-F and/or 6A-E, please submit all supporting documentation by the AUGUST 1<sup>st</sup> deadline.**

**REQUIREMENTS:**

To be eligible for the Dental Hygiene Examination, you **MUST HAVE GRADUATED** from a Dental/Dental Hygiene school accredited by the Commission on Accreditation of the American Dental Association (A.D.A.), and completed the National Board within the last ten years. **THERE ARE NO EXCEPTIONS!**

**EFFECTIVE JULY 1, 2005, APPLICANTS GRADUATING FROM A DENTAL SCHOOL NOT ACCREDITED BY THE COMMISSION ON ACCREDITATION OF THE AMERICAN DENTAL ASSOCIATION, AND WHO WISH TO SIT FOR THE DENTAL HYGIENE EXAMINATION, MUST HAVE COMPLETED FOUR (4) ACADEMIC YEARS OF POSTSECONDARY DENTAL EDUCATION. TRANSCRIPTS MUST BE TRANSLATED INTO ENGLISH, AND WE MUST RECEIVE A HEALTH PROFESSIONS LICENSURE REPORT FROM EDUCATIONAL CREDENTIAL EVALUATORS, INC. THIS DOCUMENTATION MUST BE RECEIVED BY OUR OFFICE NO LATER THAN SEPTEMBER 1, 2007.**

**DENTAL HYGIENE FEES**

Application fee	\$	50.00
Examination fee		500.00
Licensure fee		<u>105.00</u>
<b>TOTAL FEE</b>	<b>\$</b>	<b>655.00</b>

ENTIRE fees are a requirement to take the **OCTOBER 2007 Dental Hygiene Examination**. The fees must be accompanied **with** the application by the deadline date of **AUGUST 1, 2007**. Please make check or money order payable to the **Department of Health** and mail application **with fee and supporting documentation and credentials** to:

**DEPARTMENT OF HEALTH  
P.O. BOX 6330  
TALLAHASSEE, FLORIDA 32314-6330**

All supporting documentation and credentials **without fees** should be mailed to:

**DEPARTMENT OF HEALTH  
BOARD OF DENTISTRY  
4052 BALD CYPRESS WAY, BIN #C08  
TALLAHASSEE, FLORIDA 32399-3258**

**IMPORTANT INFORMATION ABOUT THE COMPUTER BASED LAWS AND RULES EXAMINATION:**

You must apply to the Board, pay the application fee and be approved prior to scheduling an examination. Applicants will be able to call Thomson Prometric Testing Centers to schedule the laws and rules examination approximately 30 days prior to the clinical examination. The study material for the Laws and Rules examination will be mailed to you with your application acknowledgement letter. Candidates may review Candidate Information Booklets for each examination approximately 45 days prior to the examination dates at the Testing Services website at [www.doh.state.fl.us/mqa/exam](http://www.doh.state.fl.us/mqa/exam). Admission slips will be mailed to all candidates approximately 30 days prior to the clinical examination. Please be aware that the computer based testing vendor will require an additional fee, payable to the vendor.

**REFUNDS**

The application fee is non-refundable under any circumstances. One-half (1/2) the examination fee is refundable if you withdraw, in writing, and it is received in our office at least 14 days prior to the examination date, or you are deemed ineligible to sit. The licensure fee is fully refundable if you choose not to take the examination or fail to pass the examination. **APPLICATION AND/OR FEES ARE NOT TRANSFERABLE TO THE NEXT EXAMINATION.**

**CREDENTIALS:**

All credentials must be **RECEIVED** in the Board of Dentistry office, at 4052 Bald Cypress Way, BIN #C08 Tallahassee, Florida 32399-3258, no later than **SEPTEMBER 1, 2007**. The only exception is “proof” of graduation and National Board scores for recent graduates; “recent graduates” has been established as **“SIX WEEKS OR LESS”**. **If you answered “yes” to question(s) 5A-F and/or 6A-E, please submit all supporting documentation by the application deadline, AUGUST 1, 2007.** Listed below are the credentials needed to be certified to sit for the **OCTOBER 2007** Dental Hygiene Examination:

- (1) **National Board Score:** The Board office must receive proof of successful completion of the National Board examination. The scores must be mailed to our office from the American Dental Association. The scores must be within the last ten years to be valid.

- (2) **Final Official Transcript:** Dental or Dental Hygiene transcripts sent to the Board of Dentistry by the registrar's office with appropriate stamps, seals, degree, and signatures are necessary. ALL final transcripts **MUST** indicate the **MATRICULATION DATE, GRADUATION DATE, DEGREE EARNED, and be EMBOSSED WITH THE SCHOOL SEAL. WE WILL NOT ACCEPT ANY TRANSCRIPT THAT HAS "ISSUED TO STUDENT" STAMPED ON THE TRANSCRIPT.** Any transcript, which does not conform to these standards, shall be deemed unofficial and unacceptable.
- (3) **Copy of Diploma:** A copy of your diploma will suffice.
- (4) **Certification of Licensure:** Each time you apply for the Dental/Dental Hygiene Examination, you must submit certification of licensure from each state you **HOLD OR HAVE HELD** a dental or dental hygiene license. This certification should state that your license is in good standing; appropriate signatures and embossed seal of the certifying Board are needed for validation. **DO NOT SEND A COPY OF YOUR LICENSE!**
- (5) **Insurance Certification:** Each time you apply for the Dental Hygiene Examination, you must submit insurance certification. Please feel free to utilize the attached form or a similar form. Certification must include an effective date and an expiration date. **WE DO NOT AND WILL NOT ACCEPT OR EVALUATE INSURANCE POLICIES!**
- (6) **Prevention of Medical Errors Requirement:** Each applicant must complete a minimum of two hours in a Prevention of Medical Errors course from an approved Board of Dentistry provider. **"PROOF OF COMPLETION"** of this course must be in the form of a certificate or letter from the provider. We have attached an abbreviated provider list for your assistance. Courses taken prior to OCTOBER 2005 will not be accepted.
- (7) **Other:** If you have changed your name in any way or added or deleted part of your name from the time you started your dental education, you must submit a copy of your name change document. If you do not have a name change document filed with the courts, submit a notarized affidavit stating the names are one and the same. If you have documents being sent to us in another name, **we need to know. If you answered, "yes" to question(s) 5A-F and/or 6A-E, please submit all supporting documentation by the application deadline date, AUGUST 1, 2007.**

**Three (3)** 2x2 photographs are required with the application (one photograph on the first copy & two (2) photographs on the second copy of the application). **Please print your name on the back of each photograph and attach these photographs to the appropriate place on the application. COMPUTER GENERATED PHOTOGRAPHS**

**ARE NOT ACCEPTABLE. YOU WILL NOT BE CREDENTIALLED WITHOUT THE REQUIRED PHOTOGRAPHS.**

**IMPORTANT INFORMATION**

**The OCTOBER 2007 Dental Hygiene examination will be held at the University of Florida College of Dentistry in Gainesville, Florida.**

For those students graduating days/weeks prior to the examination (six weeks or less), and are unable to provide final official transcripts, please note the following: Submit page 6 of the application titled "FOR RECENT GRADUATES ONLY" completed and unaltered. We will also accept a letter from the Dean, as long as it is verbatim to page 6 of the application, and is embossed with the school seal.

This document can be substituted for the official transcript **ONLY** in allowing you to sit for the **OCTOBER 2007** examination. We must have the final official transcript on record prior to licensure.

We advise that all credentials be mailed certified. Applicants for the **OCTOBER 2007** examination, who fail to comply with the "Credentials Provisions" as specified in these instructions, shall not be allowed to sit for this examination. All credentials must be received in our office on or before **SEPTEMBER 1, 2007**. There shall be no exceptions!

**IMPORTANT**

Please review Rule 64B5-2 for "General Information" purposes. Specified information concerning the examination, and your admission slip, shall be sent approximately 30 days prior to the examination date by Testing Services, (850) 245-4252. When you receive this information, **it does not indicate your file is complete**. This information is sent to ALL applicants, out of courtesy regardless of their application & credentials status. However, if your file is not complete, your admission slip **will not be honored at the examination site, and you will be asked to leave. It is the applicant's responsibility to assure that his/her file is completed by the established deadlines, as specified.**

**All dates are tentative, and could change at any time. The deadline date for the application (pages 1-3) and fee is AUGUST 1, 2007.**

The "credentials" deadline is **SEPTEMBER 1, 2007**. Please feel free to call our office to inquire concerning your file; however, please note that your file is not complete until you receive written confirmation from the Florida State Board of Dentistry. Do not send original diplomas or name-change documents. If you do, they are subject to stamping and are not returned; copies will suffice.

**AGAIN, THE ADMISSION SLIP IS NOT CONFIRMATION THAT YOUR FILE IS COMPLETE; ONLY WRITTEN CONFIRMATION FROM THE BOARD OF DENTISTRY CONFIRMS COMPLETION.**

**Please be sure to answer all questions. If any question in section 5A-F and 6A-E, on the application is answered “yes”, you must send all documentation filed with the courts, all letters/correspondence from the attorney explaining your situation, all letters from treating physicians, all information pertaining to any board of dentistry action taken against your license in another state, and any other information/documentation considered appropriate. All documentation must be official and is due by the application deadline date of AUGUST 1, 2007.**

**SPECIAL ACCOMMODATIONS:**

Please visit the Testing Services website at [www.doh.state.fl.us/mqa/Exam](http://www.doh.state.fl.us/mqa/Exam) for an application if special testing accommodations are necessary.

**ABBREVIATED PROVIDER LIST:**

For your information and assistance, please note the abbreviated provider list to secure the appropriate PREVENTION OF MEDICAL ERRORS course.

U.F. Continuing Education <b>(352) 392-4355</b>	Health Studies Institute <b>1-800-700-3454</b>
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Florida Dental Association <b>1-800-877-9922</b>	Florida Dental Hygiene Association <b>(860) 896-0603</b>
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For your information and assistance, please note the following insurance companies may help with providing malpractice insurance, **but any insurance provider will suffice.**

**DENTAL HYGIENE INSURANCE**

Marsh Affinity Group  
1440 Renaissance Drive  
Park Ridge, IL 60068-1400  
**(312) 427-1441 ext. 45105**  
**1-800-621-3008 ext. 45105**  
**1-800-503-9230**  
**[ORDPLsvcpr@seabury.com](mailto:ORDPLsvcpr@seabury.com)**

**DENTAL HYGIENE INSURANCE**

Healthcare Providers Service Organization/  
Nurses Service Organization  
159 East County Line Road  
Hatboro, PA 19040-1218  
**1-800-982-9491**  
**[www.hpsso.com](http://www.hpsso.com)**



**4. APPLICANT EXPERIENCE (DENTAL APPLICANTS ONLY)** – Hygienist applicants should skip this section and go directly to Section 5.

A. Indicate below all the time spent in internship and residency. Continue on reverse if necessary.  
Hospital (or other institution):                      Location                      From (Date):    To (Date)                      Nature of Internship or Residency:

B. Indicate below all professional practice since your graduation from Dental School. Include military service, if any. Continue on reverse or on separate sheets if necessary.  
Location of practice:                      From (Date):    To (Date)                      Nature of practice (Clinical, administrative, education):

**5. APPLICANT HISTORY – GENERAL** **(ATTACH ADDITIONAL SHEETS IF NECESSARY)**

A. Have you ever been convicted of, or entered a plea of guilty, nolo contendere, or no contest to a crime in any jurisdiction other than a minor traffic offense? You must include all misdemeanors and felonies, even if adjudication was withheld by the court so that you would not have a record or conviction. Driving under the influence or driving while impaired is not a minor traffic offense for purposes of this question.

➤ If yes, please list date, jurisdiction (state and county), offense, disposition, and all other relevant information on reverse side or an attached sheet Check  
 Yes  No

B. In the last 5 years, have you been enrolled in, required to enter into, or participated in any drug or alcohol recovery program or impaired practitioner program?  Yes  No

C. In the last 5 years, have you been treated for or had a recurrence of a diagnosed mental disorder or impairment?  Yes  No

- If 5-B or 5-C above are answered "YES", please show on reverse side or on an additional sheets on the relevant dates and circumstances of such treatment along with the names and addresses of the medical practitioners who treated you.
- In addition, it will be necessary for you to direct each of the practitioners or hospitals who treated you to furnish the Board with any information regarding such treatment.

D. In the last 5 years, have you been treated for or had a recurrence of a diagnosed physical impairment?  Yes  No

E. In the last 5 years, have you been treated for or had a recurrence of a diagnosed addictive disorder?  Yes  No

F. If you have any religious conflict that would interfere with you taking this examination on the indicated date, please contact our office in writing, explaining your situation.  Yes  No

**6. APPLICANT HISTORY – PROFESSIONAL LICENSURE**

A. Have you ever been denied the right to take a Dentistry or Dental Hygiene examination in any state?  Yes  No

B. Have you ever been refused a license to practice Dentistry, Dental Hygiene or any other license – or the renewal thereof in any state?  Yes  No

C. Have you ever had a license revoked or a certificate of registration to practice Dentistry, Dental Hygiene or any other licensed profession revoked, suspended or otherwise acted against (including probation, fine or reprimand) in a disciplinary proceeding in any state?  Yes  No

D. Are you now or have you ever been a defendant in civil litigation in which the basis of the complaint against you was in alleged negligence, malpractice or lack of professional competence?  Yes  No

E. Is there currently pending against you in any jurisdiction a complaint against your professional conduct or competence as a Dentist or Dental Hygienist?  Yes  No

- If Questions 6A, 6B, 6C, 6D or 6E above are answered "YES", you must provide complete details as to state(s), license number(s), dates, and relevant circumstances on reverse side or on attached sheets.

**7. APPLICANT LICENSURE STATUS**

A. Do you now hold or have you ever held a license to practice Dentistry or Dental Hygiene in any state, U.S. territory or foreign country? (List most recent first)  Yes  No If "YES", list ALL such licenses below

State: License # If license is not in force, how and when was validity ceased?

B. Do you have any applications for Dental or Dental Hygiene Licensure currently pending in any state or foreign country?  Yes  No If "YES", list ALL such state or jurisdictions below

**8. AFFIDAVIT**

I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past and present), business and professional associates (past and present), and all governmental agencies and instrumentalities (local, state, federal, or foreign) to release to the Florida Department of Health my information files or records requested by the department in connection with the processing of this application. I further authorize the Florida Department of Health to release to the organizations, individuals and groups listed above, any information which is material to my application. I understand that the application fee is non-refundable or transferable under any circumstances and that one half of the examination fee is refundable only if I am found to be ineligible by the board or I withdraw, in writing, at least 14 days prior to the examination date. I also understand that all dates are subject to change at any time.

I have carefully read the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for the denial, suspension, or revocation of any license to practice in the State of Florida the profession for which I am applying.

Applicant Signature \_\_\_\_\_ Date \_\_\_\_\_

**9. REMARKS**

This section is for any additional information you would like to give us. Please refer to the section number (within the application) you are referring to. An example would be: #2, Applicant Profile Data.

**THE FIRST THREE PAGES OF THIS APPLICATION MUST BE RETURNED WITH THE FEE AND THREE PICTURES BY THE APPLICATION DEADLINE FOR YOU TO BE CONSIDERED AN APPLICANT.**

**REMINDER**

**ALL CREDENTIALS AND OTHER REQUIRED MATERIALS MUST BE IN THE BOARD OFFICE BY THE TIME SPECIFIED ON THE INSTRUCTION SHEET OR YOU WILL NOT BE ALLOWED TO SIT FOR EXAMINATION. THE FIRST THREE PAGES OF THE APPLICATION AND FEE MUST BE SUBMITTED BY APPLICATION DEADLINE DATE.**

ALL APPLICANTS MUST HAVE RECEIVED A CERTIFICATE FOR SUCCESSFULLY COMPLETING THE NATIONAL BOARD WRITTEN EXAMINATION WITHIN THE PAST TEN YEARS. IF YOU ARE A CANDIDATE FOR THE DENTAL EXAMINATION AND HAVE SUCCESSFULLY COMPLETED THE NATIONAL BOARDS PRIOR TO THIS PERIOD, YOU WILL BE REQUIRED TO UPDATE PART II ONLY.

A copy of your scores should be sent directly from the ADA to this office. We will keep them on file at least two years.

**CERTIFICATE OF LICENSURE**

**Instructions:** For your convenience, you may tear out this page and send it to the Secretary of the Board in the state(s) where you hold or have held a license. However, only certificates bearing the ORIGINAL signature of certifying authorities will be accepted by the Florida Board of Dentistry.

CERTIFICATE OF SECRETARY OF BOARD OF THE STATE  
IN WHICH APPLICANT HAS OR HAS HELD A  
DENTAL/DENTAL HYGIENE LICENSE  
*(Required of all previously licensed candidates)*

I, \_\_\_\_\_

Secretary of \_\_\_\_\_  
Official name of Board

hereby certify that \_\_\_\_\_ was granted State Certificate No. \_\_\_\_\_

to practice  Dentistry  Dental Hygiene in the state of \_\_\_\_\_

on the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_, on the basis of \_\_\_\_\_

> I hereby certify that the said applicant is in good standing with this board and there have not been any disciplinary procedures against, or pending on, said applicant.

(SEAL)  
NOT VALID WITHOUT  
STATE SEAL

\_\_\_\_\_  
Secretary

> If disciplinary action has been taken, please indicate, and submit supporting information.

# CERTIFICATE REGARDING MALPRACTICE INSURANCE

For your convenience, you may send this page to your insurance company to complete.

I, \_\_\_\_\_ insurance representative for  
Print or Type Name

\_\_\_\_\_  
Name of Insurance Agency

\_\_\_\_\_  
Address

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip

\_\_\_\_\_  
(Area Code) Telephone Number

hereby certify that \_\_\_\_\_, has liability insurance coverage for  
Applicant (Print or Type Name)

injuries sustained or claimed to be sustained by a Dental or Dental Hygiene patient in the course of his/her performance for the circled examination:

OCTOBER 2007

This applicant is applying for the  Dental  Dental Hygiene examination.

Policy Number: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Expiration Date: \_\_\_\_\_

\_\_\_\_\_  
Signature of Insurance Representative

**FOR RECENT GRADUATES ONLY**  
(SIX WEEKS OR LESS)

**FINAL OFFICIAL TRANSCRIPT INFORMATION**

THIS FORM IS **ONLY** FOR THOSE APPLICANTS WHO ARE GRADUATING DAYS OR WEEKS PRIOR TO THE EXAMINATION DATE AND ARE UNABLE TO OBTAIN A **FINAL OFFICIAL TRANSCRIPT** BEFORE THE BEGINNING OF THE DENTAL OR DENTAL HYGIENE EXAMINATION. PLEASE HAVE THE DEAN OF YOUR DENTAL OR DENTAL HYGIENE SCHOOL COMPLETE THE FOLLOWING INFORMATION.

**ANY DEVIATIONS FROM THE INFORMATION REQUESTED ON THE FORM SHALL NOT BE ACCEPTED IN LIEU OF THE FINAL OFFICIAL TRANSCRIPT. POSITIVELY NO EXCEPTIONS.**

I, \_\_\_\_\_, of \_\_\_\_\_  
Name of Dean Name of University

hereby certify that \_\_\_\_\_ has completed the requirements  
Name of Applicant

for graduation, and has earned a \_\_\_\_\_ degree  
Degree Earned

On the \_\_\_\_\_ of \_\_\_\_\_, 20\_\_\_\_\_. Please witness my Hand and Official  
Day Month Year

Seal of this university or college.

\_\_\_\_\_  
Dean's signature

**If the date entered on this form is after the examination date, you will not be allowed to sit for this examination.**

**CERTIFICATION OF COMPLETION FOR  
PREVENTION OF MEDICAL ERRORS REQUIREMENT  
FOR DENTAL AND DENTAL HYGIENE APPLICANTS**

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**PLEASE MARK ONE**

Dental Exam \_\_\_\_\_ or Dental Hygiene Exam \_\_\_\_\_

Applicant's Name: \_\_\_\_\_

Name should be the same as exam application provider name

Provider Name: \_\_\_\_\_

Provider Address: \_\_\_\_\_

Title of Course: \_\_\_\_\_

Date of Course: \_\_\_\_\_

Number of credit hours offered: \_\_\_\_\_

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Signature of Authorized Agent

Date