

Board of Dentistry

P.O. Box 30670

Lansing, Michigan 48909

(517) 335-0918

www.michigan.gov/healthlicense**DENTAL HYGIENE LICENSURE INSTRUCTIONS AND CERTIFICATIONS IN
ADMINISTRATION OF LOCAL ANESTHESIA AND NITROUS OXIDE ANALGESIA**Authority: P.A. 368 of 1978, as amended
This form is for information only.

NOTE: It is your responsibility to have all required documentation sent to the Board of Dentistry. Questions regarding your application can be directed to the Michigan Board of Dentistry at (517) 335-0918 four weeks after the date you sent the application. Please allow 6-8 weeks processing time. Applications submitted without the required licensing fee, applicant's signature and date will be returned.

GENERAL INSTRUCTIONS

Please mark the appropriate type of licensure for which you are applying. Read all instructions carefully and answer all questions on the application. Please provide details on a separate sheet if necessary. Failure to correctly complete the application in its entirety may result in a delay in the processing of your application.

REGISTERED DENTAL HYGIENIST LICENSURE BY EXAMINATION

1. Submit a completed application and proper fee. An application accompanied by the appropriate fee is valid for two years. If an applicant fails to complete the requirements for licensure within two years from the date of filing the application, the application and fee are no longer valid.
2. Submit a FINAL, OFFICIAL transcript of dental education. This transcript must be sent to the Michigan Board office by the school and must show the date of graduation and the degree or certification earned. It is the applicant's responsibility to arrange to have the transcript mailed directly to the Board office by the school. (Copies, student transcripts or incomplete transcripts are not acceptable.)
3. Contact the National Board of Dental Hygiene Examiners, 211 E. Chicago Avenue, Suite 1846, Chicago, IL 60611, telephone (312) 440-2678, or website: www.ada.org/prof/ed/testing/nbdhe/index.asp, to request that an OFFICIAL REPORT of your National Board scores be sent directly to the Board office. (Copies of examination scores are not acceptable.)
4. If you have taken and passed the Northeast Regional Board Examination (NERB) at any time since January 1979, the Board office has the examination records. If you have not taken the examination, contact the office of the Northeast Regional Board of Examiners, 8484 Georgia Avenue, Suite 900, Silver Spring, MD 20910, telephone (301) 563-3300, or website: www.nerb.org, for an application and information on the site and date of the next examination.
5. If you have taken a clinical examination that is developed and scored by a state or regional board other than NERB, you may have these scores sent to the Michigan Board directly from the testing agency. Michigan will accept these clinical exam scores if the exam is substantially equivalent to the NERB clinical exam and if your scores on each part of the exam are at least 75%.

If your clinical exam scores are accepted by the Michigan Board, you will still be required to pass the dental hygiene simulated clinical written examination conducted by NERB. Contact information for NERB is listed in #4 above.

6. Verification of licensure from any state where you hold or have ever held a dental hygiene license or registration. A form is enclosed for this purpose and may be copied as needed. As most states charge a fee for this service, you should contact each state board to determine if a fee is required prior to sending them the form for completion. The Verification of Licensure form must be sent to the Michigan Board directly from the state(s) where you are or have been licensed.

A license cannot be issued until all of the above requirements have been met.

GRADUATES OF NON-ACCREDITED AND FOREIGN SCHOOLS

The Michigan Board of Dentistry Administrative Rules requires graduates of non-accredited or foreign dental hygiene schools to complete a dental hygiene program in an ADA accredited school. Upon successful completion of the program, we must receive a final, official transcript directly from the non-accredited or foreign school and the ADA accredited program. If the transcripts are not in English, a translated copy must also be provided. The applicant will then be made eligible for the NERB examination. Passing scores on the National Board Dental Hygiene Examination must also be submitted to the Board. Please refer to #3 on page 1 of these instructions.

LIMITED LICENSE

The Public Health Code of Michigan (1978 PA 368, as amended) provides that the Michigan Board of Dentistry may grant the following types of limited licenses:

1. Educational Limited License - to a person who is enrolled in postgraduate education.
2. Non-clinical Academic Limited License - to a person who functions ONLY in a non-clinical academic, research or administrative setting and who does not hold themselves out to the public as being actively engaged in the practice of dentistry, or otherwise solicit patients.
3. Clinical Academic Limited License - to a person practicing only in a clinical academic setting and who does not hold themselves out to the public as being actively engaged in the practice of dentistry, or otherwise solicit patients.

The Board of Dentistry Administrative Rules and procedures require the submission of the following for each type of limited license:

1. Proof of graduation (official transcript) sent directly from an ADA approved dental hygiene program OR a certified copy of the diploma and transcript sent directly from an unapproved school of dental hygiene. The latter shall be translated into English, if necessary.
2. Letter verifying appointment to employment or enrollment sent directly to this office from the University or training hospital. The letter of appointment must include:
 - A. Name, address and division/department of institution in which the applicant is being employed/enrolled;
 - B. Name, degree and title of applicant's supervising dentist;
 - C. Description of duties, responsibilities or courses of the applicant; and
 - D. Beginning date of employment or the beginning and anticipated ending date of the education program.

REGISTERED DENTAL HYGIENIST CERTIFICATION TO ADMINISTER LOCAL ANESTHESIA

1. Submit a completed application and proper fee. An application accompanied by the appropriate fee is valid for two years. If an applicant fails to complete the requirements for certification within two years from the date of filing the application, the application and fee are no longer valid.
2. Submit the verification of completion of training. The verification can be a certificate of completion from an approved continuing education program or completion of the Verification of Local Anesthesia Administration Training form (attached). The course should include at least 15 hours of didactic instruction and 14 hours of clinical experience in theory of pain control; selection of pain control modalities; anatomy; neurophysiology; pharmacology of local anesthetics; pharmacology of vasoconstrictors; psychological aspects of pain control; systemic complications; techniques of maxillary anesthesia; techniques of mandibular anesthesia; infection control and local anesthesia medical emergencies.
3. Submit a copy of your current certification in basic or advanced cardiac life support.

4. Passing scores on the Northeast Regional Board Examination (NERB) in local anesthesia must be sent to our office directly from NERB. The Administrative Rules of the Michigan Board of Dentistry require that you take the exam within 18 months of completion of the local anesthesia course. If you have already taken the examination, the Board office already has the scores. If you have not taken the examination, contact the office of the Northeast Regional Board of Examiners, 8484 Georgia Avenue, Suite 900, Silver Spring, MD 20910, telephone (301) 563-3300, or website: www.nerb.org, for an application and information on the examination dates and locations.
5. Upon completion of all requirements, a permanent certificate in the administration of local anesthesia will be issued. It will remain active as long as your dental hygiene license is active.

REGISTERED DENTAL HYGIENIST CERTIFICATION TO ADMINISTER NITROUS OXIDE ANALGESIA

1. Submit a completed application and proper fee. An application accompanied by the appropriate fee is valid for two years. If an applicant fails to complete the requirements for certification within two years from the date of filing the application, the application and fee are no longer valid.
2. Submit the verification of completion of training. The verification can be a certificate of completion from an approved continuing education program or completion of the Verification of Nitrous Oxide Analgesia Training form (attached). The course should include at least 4 hours of didactic instruction and 4 hours of clinical experience that includes instruction in nitrous oxide analgesia medical emergency techniques; pharmacology of nitrous oxide; nitrous oxide techniques; and training in the selection of pain control modalities if such a course is available.
3. Submit a copy of your current certification in basic or advanced cardiac life support.
4. Passing scores on the Northeast Regional Board (NERB) Nitrous Oxide Examination for Dental Hygienists must be sent to our office directly from NERB. The Administrative Rules of the Michigan Board of Dentistry require that you take the exam within 18 months of completion of the course in nitrous oxide analgesia. If you have already taken the examination, the Board office already has the scores. If you have not taken the examination, contact the office of the Northeast Regional Board of Examiners, 8484 Georgia Avenue, Suite 900, Silver Spring, MD 20910, telephone (301) 563-3300, or website: www.nerb.org, for an application and information on the examination dates and locations.
5. Upon completion of all requirements, a permanent certification in the administration of nitrous oxide analgesia will be issued. It will remain active as long as your dental hygienist license is active.

GENERAL INFORMATION

1. **NAME AND/OR ADDRESS CHANGES:** If your name and/or address changes please notify the Board of Dentistry in writing. To change a name or address, you can download the [Data Change/Duplicate License Request Form](#) from our website www.michigan.gov/healthlicense and fax it to (517) 373-2179 or mail the form to Bureau of Health Professions, PO Box 30670, Lansing, MI 48909. Telephone calls are NOT accepted for these changes.
2. **REFUND POLICY:** If you wish to withdraw your application, you may be eligible for a partial refund. You must notify the Board of Dentistry in writing to request a refund.
3. **NOTE:** If you have ever been licensed in another state and you have a current disciplinary sanction on that license, (even if the license is inactive), you are **not** eligible for licensure in Michigan according to the Public Health Code, PA 368, as amended, Section 222.16174 (3). Sanctions include probation, limitation, suspension, revocation or fine. Upon resolution of the sanction and verification that the license is active with no disciplinary action in effect, you can proceed with the filing of an application for a Michigan license or registration.

ORIGINAL LICENSES ARE VALID FOR ONE YEAR OR LESS; SUBSEQUENT RENEWALS ARE FOR A THREE-YEAR PERIOD.



STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH
LANSING

JENNIFER M. GRANHOLM
GOVERNOR

JANET OLSZEWSKI
DIRECTOR

CRIMINAL BACKGROUND CHECK FINGERPRINT REQUEST FORM INSTRUCTIONS (out of state locations)

Procedure to search criminal history records when fingerprints are required by law:

1. Contact a local law enforcement , governmental, or private fingerprinting agency to see if they can perform an ink fingerprint on an FBI (FD-258) card. The ink fingerprint must be completed on the FBI card.
2. Submit the FBI card with your fingerprints, the completed Livescan Fingerprint Request Form (attached) and a business check or money order for \$65.25 made payable in U.S. Funds to Integrated Biometric Technology at the following address:

IBT c/o Livescan
1650 Wabash Ave. Ste. D
Springfield, IL 62704

3. IBT will submit your fingerprints to the Michigan State Police for analysis.
4. If no criminal history information is found, the Bureau of Health Professions will be notified within 24-48 hours.
5. If criminal history information is found, the Michigan State Police will send the record directly to the Bureau of Health Professions for review.
6. Call IBT toll-free at 1-866-226-2952 (8 am - 5 pm EST) if you have any questions.
7. IBT is under contract with the Michigan State Police (MSP) to provide fingerprint services. For questions, call MSP at (517) 322-1956.

LIVESCAN FINGERPRINT REQUEST FORM

Fingerprint Date:	TCN:
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Type of I.D. Presented:	Type of Licensure/Registration:
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Applicant Instructions: Take this completed form along with your picture I.D. to your scheduled appointment. Please print clearly.

First Name:	Middle Name:	Last Name:	
Street Address:			
City:	State:	ZIP Code:	
Daytime Telephone Number w/ Area Code:		State or Country of Birth:	
Date of Birth (MM/DD/YYYY):	Race:	Sex:	
Height:	Weight:	Eye Color:	Hair Color:

REQUESTING AGENCY INFORMATION

Agency I.D. Number: 71734k	Agency Name: Department of Community Health, Bureau of Health Professions
Reason Fingerprinted: LHP - Licensed Health Care Professional	Cost: \$65.25

****Disclaimer:** Any and all errors that result in dual fingerprinting (Duplicate transmission to MSP), multiple fingerprint codes, fingerprints processed with incorrect fingerprint codes/reasons, etc., are the responsibility of the **LIVESCAN AGENCY**. MSP will charge for dual fingerprinting (transmission), etc.

Board of Dentistry

P.O. Box 30670

Lansing, MI 48909

(517) 335-0918

www.michigan.gov/healthlicense

**APPLICATION FOR DENTAL HYGIENIST REGISTRATION
AND CERTIFICATIONS**

Authority: Public Act 368 of 1978, as amended

If this form is not completed, a license will not be issued.

Type or Print Only

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Board Use Only
License Number
Date of Licensure

I AM APPLYING FOR THE FOLLOWING:

- Dental Hygienist Registration Fee: \$45.00 71-2902-01
- Dental Hygienist Clinical Academic License Fee: \$30.00 71-2902-03
- Dental Hygienist Non-Clinical Academic License Fee: \$30.00 71-2902-03
- Dental Hygienist Educational Limited License Fee: \$30.00 71-2902-05
- Local Anesthesia Certification Fee: \$10.00 71-2902-11
- Nitrous Oxide Analgesia Certification Fee: \$10.00 71-2902-11

Your check or money order drawn on a U.S. financial institution and made payable to the **STATE OF MICHIGAN** must accompany this application. **DO NOT SEND CASH.** Fees are deposited upon receipt and can only be refunded under refund rules promulgated by the Department.

First Name	Middle Name	Last Name
U.S. Social Security Number	Date of Birth	Daytime Telephone Number
Street Address		
City	State	ZIP Code
All Previous Names and/or Birth Name Used (if applicable)		
Have you ever held a health professional license in Michigan?		
<input type="checkbox"/> No <input type="checkbox"/> If yes, list Michigan permanent I.D./license number and expiration date: _____		

Check the appropriate answer to each of the following questions. NOTE: Attach a detailed explanation for any Yes answer you check.

1. Have you ever been convicted of a felony?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. Have you ever been convicted of a misdemeanor punishable by imprisonment for a maximum term of 2 years?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. Have you ever been convicted of a misdemeanor involving the illegal delivery, possession, or use of alcohol or a controlled substance (including motor vehicle violations)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4. Have you been treated for substance abuse in the past 2 years?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5. Have you had 3 or more malpractice settlements, awards, or judgments in any consecutive 5 year period?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
6. Have you had one or more malpractice settlements, awards, or judgments totaling \$200,000 or more in any consecutive 5 year period?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
7. Have you ever had a federal or state health professional license revoked, suspended, or otherwise disciplined; been denied a license; or currently have disciplinary action pending against you?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
8. Have you ever been censured, or requested to withdraw from a health care facility's staff or had your health care facility staff privileges involuntarily modified?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

The Department of Community Health will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability or political beliefs. If you need assistance with reading, writing, hearing, etc., under the Americans with Disabilities Act, you may make your needs known to this agency.

Name _____

9. Do you hold or have you ever held a full dental hygienist license (other than an educational, temporary or limited license) in any state? If yes, list each state, the license number, the date issued, and how the license was obtained (either endorsement or examination). **DO NOT LIST TEMPORARY LICENSES. You must have each state board verify licensure directly to this board office. (Attach additional sheets if necessary.)** Yes No

State	License/Registration Number	Date of Issue	How Obtained (Endorsement or examination)

10. Provide a complete chronological record of your educational preparation. Attach additional sheets if necessary.

Name and Address of Institution	Dates of Attendance From	To	Degree
DENTAL HYGIENE EDUCATION -			
Name and Address of Institution			
LOCAL ANESTHESIA EDUCATION -			
Name and Address of Institution			
NITROUS OXIDE ANALGESIA EDUCATION -			
Name and Address of Institution			

11. Have you passed all parts of the National Board Exams? Yes No
 If No, please list the date you are scheduled to take the exam: _____

12. Have you ever taken the Northeast Regional Board Examination (NERB) ? Yes No
 If No, please list the date you are scheduled to take the exam: _____
 If Yes, complete the following:
 Examination Date: _____ Pass Fail
 Reexamination Date: _____ Pass Fail

13. Have you ever taken the Northeast Regional Board Examination in local anesthesia ? Pass Fail
 Examination Date: _____

CERTIFICATION

I understand that it is the policy of this agency to secure a criminal conviction history as part of the pre-licensure screening process. I authorize this agency to use the information provided in this application to obtain a criminal conviction history file search from the Central Records Division of the Michigan Department of State Police or other law enforcement or judicial record-keeping organization.

I further consent to the release of information to this agency regarding any disciplinary investigations conducted by a similar licensure, registration, or specialty certification board of this or any other state, of the United States military, of the federal government, or of another country.

The statements in this application are true and correct. I have not withheld information that might affect the decision to be made on this application. In signing this application, I am aware that a false statement or dishonest answer may be grounds for denial of my application or revocation of my license and that such misrepresentation is punishable by law.

Signature of Applicant _____

Date _____

Michigan Department of Community Health
Board of Dentistry
 P.O. Box 30670
 Lansing, MI 48909
 (517) 335-0918

VERIFICATION OF LOCAL ANESTHESIA ADMINISTRATION TRAINING

Authority: Public Act 368 of 1978, as amended

SECTION I - APPLICANT INFORMATION

Applicant Please complete the information in Section I and mail this form to the school where you trained in the didactic and clinical administration of local anesthesia.

First Name	Middle Name	Last Name	
U.S. Social Security Number	Date of Birth	Michigan Permanent I.D. Number and Expiration Date	
Street Address			
City		State	ZIP Code
Daytime Telephone Number	All Previous Names and/or Birth Name Used (if applicable)		

Applicant's Signature	Date
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APPLICANT: UPON COMPLETION OF SECTION I, SEND THIS FORM TO THE PROGRAM DIRECTOR FOR COMPLETION OF SECTION II.

The Department of Community Health will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability or political beliefs. If you need assistance with reading, writing, hearing, etc., under the Americans with Disabilities Act, you may make your needs known to this agency.

THIS SIDE TO BE COMPLETED BY THE PROGRAM DIRECTOR

INSTRUCTIONS FOR COMPLETING SECTION II:

The applicant listed on the previous page is seeking certification to administer local anesthesia in Michigan. Please complete Section II and the certification below concerning training received by the applicant. When the form is complete, mail it directly to the Board of Dentistry at the address shown on page 1 of this form.

SECTION II - VERIFICATION OF TRAINING

Name of School	Telephone Number	
Street Address		
City	State	ZIP Code
Dates of Training		
From:		To:

CERTIFICATION

I certify that _____ has completed
(Applicant's Name)

a minimum of 15 hours of didactic instruction and 14 hours of clinical experience. The following topics were covered in the training. Please check all that apply:

- Theory of pain control
- Selection of pain control modalities
- Anatomy
- Neurophysiology
- Pharmacology of local anesthesia
- Pharmacology of vasoconstrictors
- Psychological aspects of pain control
- Systemic complications
- Techniques of maxillary anesthesia
- Techniques of mandibular anesthesia
- Infection control
- Local anesthesia medical emergencies

 Authorized Signature (Dean, Registrar, etc.)

 Date

(SCHOOL SEAL)

 Type or Print Name and Title

Michigan Department of Community Health
Board of Dentistry
 P.O. Box 30670
 Lansing, MI 48909
 (517) 335-0918

VERIFICATION OF NITROUS OXIDE ANALGESIA TRAINING

Authority: Public Act 368 of 1978, as amended

SECTION I - APPLICANT INFORMATION

Applicant Please complete the information in Section I and mail this form to the school where you trained in the didactic and clinical use of nitrous oxide analgesia.

First Name	Middle Name	Last Name	
U.S. Social Security Number	Date of Birth	Michigan Permanent I.D. Number and Expiration Date	
Street Address			
City	State	ZIP Code	
Daytime Telephone Number	All Previous Names and/or Birth Name Used (if applicable)		

Applicant's Signature	Date
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APPLICANT: UPON COMPLETION OF SECTION I, SEND THIS FORM TO THE PROGRAM DIRECTOR FOR COMPLETION OF SECTION II.

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THIS SIDE TO BE COMPLETED BY THE PROGRAM DIRECTOR

INSTRUCTIONS FOR COMPLETING SECTION II:

The applicant listed on previous page is seeking certification to administer nitous oxide analgesia in Michigan. Please complete Section II and the certification below concerning training received by the applicant. When the form is complete, mail it directly to the Board of Dentistry at the address shown on page 1 of this form.

SECTION II - VERIFICATION OF TRAINING

Name of School	Telephone Number	
Street Address		
City	State	ZIP Code
Dates of Training		
From:	To:	

CERTIFICATION

I certify that _____ has completed a minimum
(Applicant's Name)
of 4 hours of didactic instruction and 4 hours of clinical experience in the administration of nitrous oxide analgesia.

The following topics were covered in the training. Please check all that apply:

- Nitrous oxide analgesia medical emergency techniques
- Pharmacology of nitrous oxide
- Nitrous oxide techniques
- Selection of pain control modalities (if available)

Authorized Signature (Dean, Registrar, etc.)

Date

Type or Print Name and Title

(SCHOOL SEAL)

Michigan Department of Community Health
Bureau of Health Professions
P.O. Box 30670
Lansing, MI 48909
www.michigan.gov/healthlicense

VERIFICATION OF LICENSURE OR REGISTRATION IN ANOTHER STATE

Authority: Public Act 368 of 1978, as amended.

PART I: To be completed by the applicant and forwarded to the appropriate State Licensing Board for completion.

Check the profession for which you are requesting verification.			
<input type="checkbox"/> Audiology	<input type="checkbox"/> Medicine	<input type="checkbox"/> Osteopathy	<input type="checkbox"/> Psychology
<input type="checkbox"/> Chiropractic	<input type="checkbox"/> Nursing	<input type="checkbox"/> Pharmacy	<input type="checkbox"/> Respiratory Therapy
<input type="checkbox"/> Counseling	<input type="checkbox"/> Nursing Home Adm.	<input type="checkbox"/> Physical Therapy	<input type="checkbox"/> Sanitarians
<input type="checkbox"/> Dentistry	<input type="checkbox"/> Occupational Therapy	<input type="checkbox"/> Physician's Assistants	<input type="checkbox"/> Social Work
<input type="checkbox"/> Marriage & Family Therapy	<input type="checkbox"/> Optometry	<input type="checkbox"/> Podiatry	<input type="checkbox"/> Veterinary
First Name	Middle Name	Last Name	
Previous Names Used	Date of Birth	U. S. Social Security Number	
State Board	License Number	Date of Issue	

The applicant listed above has applied for licensure in Michigan and has indicated licensure in your State. Please complete Part II of this form and return it to the appropriate Michigan Board at the address shown above.

PART II: To be completed by the State Licensing Board.

Type of License:	Original Issue Date	Expiration Date
Basis for Issuance of License:		
<input type="checkbox"/> Examination - Please indicate type of exam (National, Regional, State, etc.) _____		
<input type="checkbox"/> Endorsement - Please indicate name of state _____		
License Status	Has the applicant incurred any formal or informal actions in your State?	
<input type="checkbox"/> Current <input type="checkbox"/> Lapsed <input type="checkbox"/> Inactive	<input type="checkbox"/> No <input type="checkbox"/> Yes - If Yes, Please attach certified copies of any actions.	
Are formal or informal actions pending?	Has the applicant's license ever been limited, denied, surrendered, reprimanded, suspended or revoked?	
<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	

CERTIFICATION

I hereby verify, to the best of my knowledge, the information above is true to the records of this Board.

Signature

Date

Type or Print Name

(S E A L)

Title

Full Name of Licensing Board