

Board of Dentistry

P.O. Box 30670

Lansing, Michigan 48909

(517) 335-0918

www.michigan.gov/healthlicense**DENTAL HYGIENE ENDORSEMENT INSTRUCTIONS**

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 three 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.

REGISTRATION BY ENDORSEMENT INSTRUCTIONS

1. The Michigan Board of Dentistry may issue a registration by endorsement to an applicant who is currently licensed in another state if that state's licensure requirements are substantially equivalent to those required in Michigan and the applicant has been licensed in that state for at least two (2) years.
2. Please mark the appropriate type of registration/certification for which you are applying. Read all instructions carefully and answer all questions on the application including providing details on a separate sheet if necessary. Failure to correctly complete the application in its entirety may delay the processing of your application. You must provide a complete listing of **all states** (excluding temporary licenses) in which you have **ever** held a dental hygiene license.
3. 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to complete the requirements for licensure within two years from the date of filing the application, the application is no longer valid.
4. **Effective October 1, 2008**, all applicants for a health profession license or registration in Michigan are required to submit fingerprints and undergo a criminal background check. Please see the attached instructions. The Michigan Board is not able to accept fingerprints that have been obtained for any other purpose. Your license or registration will not be issued until this process is complete.
5. Complete the application for registration in its entirety and submit it with the required fee. Applications submitted without the licensing fee will be returned.
6. You must complete **PART I** of the enclosed Endorsement Certification form and mail it to the state in which you were originally licensed by examination for completion of **PART II** by that state. **Contact your original state of licensure for information regarding fees charged for this service.**
7. In addition to the Endorsement form from your original state of licensure, a Verification of Licensure form must be forwarded to this office **from EACH** additional state in which you hold or have ever held a dental hygiene license. The Verification of Licensure form may be duplicated. You may wish to check with the other state(s) as a fee is usually charged for this service.
9. Submit a FINAL, OFFICIAL transcript of grades from your dental hygiene program. **The transcript must be submitted directly to this office from your school.**
10. Contact the National Board of Dental Hygiene Examiners, 211 E. Chicago Avenue, Ste 1846, Chicago, Illinois 60611, telephone (312) 440-2678, or website: www.ada.org/prof/ed/testing/natboard, 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.)

11. Dental Hygienists who have been licensed in another state for less than 2 years: If you have taken a regional or state examination other than NERB, please arrange to have the Regional/State Examination booklet and your scores submitted directly to this office from the testing agency. The examination you took will be evaluated by the Michigan Board of Dentistry to determine if it is equivalent to the NERB. You will be notified of the Board's decision either to accept the examination you took or to require that you pass all or part of the NERB examination.
12. Dental Hygienists who have been licensed in another state for 2 or more years: If you have taken a regional or state examination other than NERB, please arrange to have the Regional/State Examination scores submitted directly to this office from the testing agency.

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. **Effective October 1, 2008**, all applicants for a health profession license or registration in Michigan are required to submit fingerprints and undergo a criminal background check. Please see the attached instructions. The Michigan Board is not able to accept fingerprints that have been obtained for any other purpose. Your license or registration will not be issued until this process is complete.
3. 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.
4. Submit verification of current certification in basic or advanced cardiac life support. The verification should be a notarized copy of your current certification.
5. Submit proof of completion of the Northeast Regional Board Examination (NERB) in local anesthesia within 18 months of completion of the course work. 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.
6. If you have taken a regional or state examination in local anesthesia other than NERB, please arrange to have the Regional/State Examination booklet (test outline) submitted directly to this office from the testing agency. The examination you took will be evaluated to determine if it is equivalent to the NERB. You will be notified of the Board's decision either to accept the examination you took or to require that you pass the NERB examination.
7. 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. **Effective October 1, 2008**, all applicants for a health profession license or registration in Michigan are required to submit fingerprints and undergo a criminal background check. Please see the attached instructions. The Michigan Board is not able to accept fingerprints that have been obtained for any other purpose. Your license or registration will not be issued until this process is complete.
3. 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 in nitrous oxide analgesia medical emergency techniques; pharmacology of nitrous oxide; and nitrous oxide techniques and training in selection of pain control modalities should be included, if available.
4. Submit verification of current certification in basic or advanced cardiac life support. The verification should be a notarized copy of your current certification.
5. Currently no examination is available regarding the administration of nitrous oxide.
6. 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 333.16174 (2). 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.
4. **CONTINUING EDUCATION:** This license has a continuing education requirement for renewal. Please check our website at www.michigan.gov/healthlicense for more information on the specific requirements.
PLEASE NOTE: You are not required to complete any continuing education credits in order to renew your license for the first time because you will not have held your license for a full three-year period.
5. **ORIGINAL LICENSES ARE VALID FOR ONE YEAR OR LESS; SUBSEQUENT RENEWALS ARE FOR A THREE-YEAR PERIOD.**



RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

STEVEN H HILFINGER
DIRECTOR

**CRIMINAL BACKGROUND CHECK
FINGERPRINT REQUEST FORM INSTRUCTIONS- (Michigan locations only)
AGENCY ID NUMBER IS 71734k**

Applicants for a Michigan health professional license may have their fingerprints taken by either L-1 Identity Solutions or Cogent Systems. Whether you use L-1 Identity Solutions or Cogent Systems, the Agency ID Number for health professional licensing is 71734k. This ID number MUST be used in order to have your fingerprint report sent to the Bureau of Health Professions. Keep the receipt you receive once your fingerprints are taken.

You must bring the Livescan Fingerprint Request Form (attached) and a driver's license or other state or federal-issued picture identification to your fingerprint appointment. You will also be required to pay a separate fee to the fingerprinting agency when registering for or scheduling your appointment.

When your fingerprints are taken, a technician will perform a scan of your fingerprints and submit the data electronically to the Michigan State Police. If no criminal history is found, the Bureau of Health Professions will be notified. If criminal history information is found, the Michigan State Police will send the record directly to the Bureau of Health Professions for review.

Information about fees and scheduling your fingerprint appointment with L-1 Identity Solutions can be found at www.L1enrollment.com or by calling 1-866-226-2952.

Information about fees and registering to have your fingerprints taken by Cogent Systems can be found at www.cogentid.com/index.htm. Click on Michigan and then select the Cogent MAPS (Michigan Applicant Processing Service) option. If you are using Cogent Systems, the MAPS option must be used for health professional licensing purposes. Cogent Systems can be reached by phone at 1-877-838-4903. E-mail inquiries about using Cogent Systems may be sent to mihelp@cogentsystems.com.



RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

STEVEN H HILFINGER
DIRECTOR

**CRIMINAL BACKGROUND CHECK
FINGERPRINT REQUEST FORM INSTRUCTIONS
(For applicants out of state or out of country)**

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 or on another state's official fingerprint card. The ink fingerprint must be completed on card stock.
2. Submit the card with your fingerprints, the completed Livescan Fingerprint Request Form (attached) and a business check or money order for \$62.75 made payable in U.S. Funds to L-1 Identity Solutions to the following address:

L-1 Enrollment Services/LiveScan Processing Unit
1650 Wabash Ave. Ste. D
Springfield, IL 62704

3. Please include a daytime telephone number or e-mail address where you can be reached if there are any questions.
4. L-1 Identity Solutions will submit your fingerprints to the Michigan State Police for analysis.
5. If no criminal history information is found, the Bureau of Health Professions will be notified.
6. If criminal history information is found, the Michigan State Police will send the record directly to the Bureau of Health Professions for review.
7. Call L-1 Identity Solutions toll-free at 1-866-226-2952 (8 am - 5 pm EST) if you have any questions.
8. L-1 Identity Solutions is under contract with the Michigan State Police (MSP) to provide fingerprint services. For questions, call MSP at (517) 241-0606.

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 Licensing and Regulatory Affairs, Bureau of Health Professions
Reason Fingerprinted: LHP - Licensed Health Care Professional (MCL333.16174)	Cost:

****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.

Name _____

9. Do you hold or have you ever held a license for your profession (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). **You must have each state board verify licensure directly to this board office. (Attach additional sheets if necessary.)** Yes No

State	License Number	Date of Issue	How obtained (Endorsement or examination)

10. Have you previously applied for licensure to the Michigan Board? Yes No

11. Name the state from which you are endorsing: _____

12. What examination did you take to obtain licensure?

REGIONAL BOARD: (If NERB, list date of exam) _____

STATE CONSTRUCTED: List state and date of exam _____

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

Name and Address of Institution	Dates of Attendance		Degree
	From	To	

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 Licensing and Regulatory Affairs
Board of Dentistry
 P.O. Box 30670
 Lansing, MI 48909
 (517) 335-0918
www.michigan.gov/healthlicense

ENDORSEMENT CERTIFICATION

Authority: Public Act 368 of 1978, as amended
 If this form is not completed, a license will not be issued.

SECTION I - APPLICANT INFORMATION

Instructions: Complete Section I. Type or print your legal name exactly as it appears on your application. Send this form to the state licensing agency for completion of Section II. This certification must be submitted directly to the Michigan Board of Dentistry by the state licensing agency where you were originally licensed.

First Name	Middle Name	Last Name
Social Security Number		Date of Birth
Street Address		
City		
State		ZIP Code
Daytime Phone Number	All Previous Names and/or Birth Name Used (if applicable)	

Professional School Attended
Street Address
City
State
ZIP Code

Signature of Applicant	Date
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APPLICANT: UPON COMPLETION OF SECTION I, SEND THIS FORM TO THE LICENSING AGENCY IN THE STATE FROM WHICH YOU ARE ENDORSING FOR COMPLETION OF SECTION II OF THIS FORM.

Name

THIS SIDE TO BE COMPLETED BY THE LICENSING AGENCY IN THE STATE FROM WHICH THE APPLICANT IS ENDORSING

SECTION II - CERTIFICATION OF LICENSE INFORMATION

Please complete the following, noting any exceptions to the information requested. Return this completed certification directly to the Michigan Board of Dentistry at the address shown on the reverse side of this form.

Applicant's Name as Licensed	
License Number	Date Issued
License Status	Expiration Date
<p>1. Has the applicant incurred any disciplinary proceedings in your state? (Please attach certified copies of any actions.) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. Are disciplinary proceedings pending? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>3. Has the applicant's license ever been limited, denied, surrendered, suspended or revoked? (Please attach certified copies of any actions.) <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	

EXAMINATION INFORMATION

Licensure requirements in effect at the time applicant was licensed in your state:		
<input type="checkbox"/> Degree <input type="checkbox"/> Accredited School <input type="checkbox"/> National Board Exams <input type="checkbox"/> Licensure Exam - Please Specify <input type="checkbox"/> Regional <input type="checkbox"/> State Constructed <input type="checkbox"/> Other: Please Specify _____	<table border="1"> <tr> <td>Dates of Examination</td> </tr> </table>	Dates of Examination
Dates of Examination		

Name

WRITTEN/COMPREHENSIVE EXAMINATION

EXAMINATION SUBJECT	TOTAL POSSIBLE POINTS	APPLICANT'S SCORE	EXAMINATION SUBJECT	TOTAL POSSIBLE POINTS	APPLICANT'S SCORE

CLINICAL EXERCISES EXAMINATION

EXAMINATION SUBJECT	TOTAL POSSIBLE POINTS	APPLICANT'S SCORE	EXAMINATION SUBJECT	TOTAL POSSIBLE POINTS	APPLICANT'S SCORE

What was the passing score that was in effect at the time the above examination was taken?

Please describe the criteria used to determine the passing level:

Authorized Signature

Date of Signature

Print or Type Name and Title

State Board

(S E A L)

Michigan Department of Licensing and Regulatory Affairs
Board of Dentistry
 P.O. Box 30670
 Lansing, MI 48909
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www.michigan.gov/healthlicense

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 Licensing and Regulatory Affairs 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 Licensing and Regulatory Affairs
Board of Dentistry
 P.O. Box 30670
 Lansing, MI 48909
 (517) 335-0918
www.michigan.gov/healthlicense

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.

The Department of Licensing and Regulatory Affairs 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 previous page is seeking certification to administer nitrous 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)

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"/> Acupuncture	<input type="checkbox"/> Medicine	<input type="checkbox"/> Pharmacy
<input type="checkbox"/> Audiology	<input type="checkbox"/> Nursing	<input type="checkbox"/> Physical Therapy
<input type="checkbox"/> Chiropractic	<input type="checkbox"/> Nursing Home Admin.	<input type="checkbox"/> Physician's Assistants
<input type="checkbox"/> Counseling	<input type="checkbox"/> Occupational Therapy	<input type="checkbox"/> Podiatry
<input type="checkbox"/> Dentistry	<input type="checkbox"/> Optometry	<input type="checkbox"/> Psychology
<input type="checkbox"/> Marriage & Family Therapy	<input type="checkbox"/> Osteopathy	<input type="checkbox"/> Respiratory Therapy
<input type="checkbox"/> Sanitarian	<input type="checkbox"/> Social Work	<input type="checkbox"/> Veterinary Medicine
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