STATE OF MAINE
Board of Dental Practice

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VERIFICATION OF SUPERVISED CLINICAL PRACTICE HOURS REQUIRED FOR DENTAL THERAPY PRACTICE AUTHORITY

Dental Therapist Information (To be completed in full by Applicant)		
Name of Dental Therapist:	License Number:	
Mailing Address:		
City:	State:	Zip Code:
Work Telephone:	Original Licensure Date:	
List Place(s) of Employment During Clinical Practice: **Use separate sheet if necessary.** 1._____ 2._____ 3._____ 4._____		

Dentist Supervision Information (To be completed in full by Supervisor)		
Name of Dentist:	License Number:	
Mailing Address:		
City:	State:	Zip Code:
Work Telephone:		
Note: A separate verification form must be submitted if more than one supervising dentist.		

Dental Therapy Clinical Experience Information (To be completed in full by Supervisor)
Dates of Clinical Practice Supervision: Start (month/day/year): _____ End: (month/day/year):_____ Total Number of Dental Therapy Clinical practice hours completed: _____
Total Number of Adult Patient Clinical Care Cases: _____
Total Number of Pediatric Patient (aged 12 and under) Clinical Care Cases: _____ 1
Enclose a copy of the signed written practice agreement listing the services you authorized the dental therapist to perform under your supervision, including any limitations to the scope of practice. On a separate sheet, submit a detailed assessment of the dental therapist's ability in each of the clinical practice areas noted in the agreement.

AFFIDAVIT OF DENTIST - SUPERVISOR
I have read and completed this form and attest that the supervised clinical experience information is true to the best of my knowledge. Should I furnish any false information in this form, I hereby agree that such act shall constitute cause for disciplinary action to practice dentistry in the state of Maine. **DENTIST-SUPERVISOR SIGNATURE:** _____ **DENTIST-SUPERVISOR PRINTED NAME**: _____ DATE: _____

Patient Record Reviews
(To be submitted by Applicant)

Dental therapy applicants must submit five, complete patient records that demonstrate compliance with Board Rules Chapter 12 §§ (G) and (H) and competencies of clinical dental therapy practice as outlined in each signed, written practice agreement. Each patient record must be deidentified for confidentiality purposes, and must contain the following:

1. Medical and dental history form(s); record of examination(s), diagnosis(es), treatment plan(s), documented informed consent(s), referrals and/or consultations, progress notes, anesthesia/sedation record(s) as applicable; and patient billing record(s); and
2. Dental radiographs, photographs, and/or images are to be submitted in a digital format on a disk or flash drive. All images must include patient information and date of image taken.

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The patient records will be reviewed for compliance with record-keeping regulations as well as evidence of demonstrating critical thinking and decision making during the provision of dental therapy services. The patient records selected ***must*** contain representative examples of the treatment and/or services provided by you during your supervised clinical practice as a dental therapist.