STATE OF MAINE

BOARD OF DENTAL PRACTICE

APPLICATION FOR INDEPENDENT PRACTICE DENTAL HYGIENE AUTHORITY

- Standard Application

Maine Board of Dental Practice
143 State House Station
Augusta, ME 04333-0143

Office Telephone: (207) 287-3333
Office Facsimile: (207) 287-8140
TTY users call Maine Relay 711
Website: www.maine.gov/dental

Revised: 12/2022

APPLICANT INFORMATION GUIDE

The application material you have requested from the Board of Dental Practice is enclosed. It contains all the relevant materials you need to complete your application in the State of Maine. Please read all the information carefully. If you have any questions after reading this packet, please call or e-mail our office.

FURNISHED TO APPLICANT

- Application Information Guide
- Individual Application
- Verification of Licensure Form
- Verification of Clinical Practice Form
- Maine's Mandated Reporter Requirements for Suspected Child Abuse website
- Maine's Medical Professionals Health Program website

ADDITIONAL RESOURCES

- Board of Dental Practice Statute, Title 32, Chapter 143

Please read these carefully and review periodically for changes. You are responsible for knowing and complying with all Maine Laws throughout your licensure.
Available: http://legislature.maine.gov/legis/statutes/32/title32ch143sec0.html or call (207) 287-3333

- Board of Dental Practice Rules

Please read these carefully and review periodically for changes. You are responsible for knowing and complying with all Board Rules throughout your licensure.
Available: http://www.maine.gov/sos/cec/rules/02/chaps02.htm#313 or call (207) 287-3333

- Statutory Authority, Titles 5 & 10

Available: http://www.mainelegislature.org/legis/statutes/10/title10ch901sec0.html

http://www.mainelegislature.org/legis/statutes/5/title5ch341sec0.html

APPLICATION INFORMATION GUIDE

- National Practitioner Data Bank (NPDB): You are required to obtain a self-query report and submit the report to the Board with your application. Please visit NPDB's website at http://www.npdb.hrsa.gov/index.jsp or contact them directly at: 1-800-767-6732.

- Verification of Licensure Form: The Board requires that you submit verification of licensure for any professional license ever held, i.e. expired, inactive, retired, etc. from any licensing authority as part of the application materials.

- Mandated Reporter Requirements for Suspected Child Abuse: Maine law requires that dentists and dental hygienists immediately report or cause a report to be made to the Maine Department of Health and Human Services (DHHS) when the licensee knows or has reasonable cause to suspect that a child has been or is likely to be abused or neglected or that a suspicious child death has occurred. Mandated Reporter Training and additional information regarding mandated reporting can be found at: https://www.maine.gov/dhhs/ocfs/provider-resources/reporting-suspected-child-abuse-and-neglect/mandated-reporter-information

- Maine's Medical Professionals Health Program (MPHP): The MPHP works cooperatively with six Maine boards of licensure, hospitals, medical staffs, and professional associations to ensure that professionals in need of treatment and services get the help they need. The MPHP is not a treatment program, but their staff will help professionals to find the resources they need, to better understand the treatment and recovery process, and to implement strategies for return to safe practice. https://www.mainemphp.org/

- 10 Day Reporting Requirement: Please be advised, pursuant to 32 MRS §18352, licensees and applicants are to report to the Office, in writing, any change of name or address on file with the Office, any criminal conviction, any revocation, suspension or other disciplinary action taken in this or any other jurisdiction against any occupational or professional license held, or any material change set forth in this application within ten (10) days:

- Please submit your application materials to the Board by USPS mail to our office. **Faxed submissions will not be accepted**. Your application will be reviewed and processed in the order that it was received. Application reviews generally take at least two weeks, barring any action required by the full Board, or any high volume renewal of licensure periods.

- Pursuant to M.R.S. Chapter 143 §18341 (3), An applicant has 90 days after being notified of the materials needed to complete the application to submit those materials to the board. You will be notified by mail if there are deficiencies with your application. You may also check the Board's website at www.maine.gov/dental. It is the responsibility of the applicant to see that all documentation is completed and returned to the Board for consideration. Failure to complete the application within that 90-day period may result in a denial of the application.

INDEPENDENT PRACTICE DENTAL HYGIENE AUTHORITY

Pursuant to 32 M.R.S. §18302 §§ 23, an Independent practice dental hygienist "…means a person who holds a valid license as a dental hygienist issued by the board and who is authorized to practice independent dental hygiene."

Scope of practice – see 32 M.R.S. §18375

STANDARD APPLICATION

An application for examination shall include:

- ☐ Completed and signed Application (pgs. 1-10)
- ☐ Payment of fees: application fee $50.00; authority fee $50.00

Note: All fees can be in one payment.

- ☐ Completed Verification of Licensure Form(s)
- ☐ Completed Verification of Clinical Supervision Form(s)
- ☐ NPDB Self-Query Report (See instructions on Application Information Guide)
- ☐ Current; valid CPR Certification

STATE OF MAINE / BOARD OF DENTAL PRACTICE
Mailing Address: 143 State House Station, Augusta, Maine 04333-0143
Phone: (207) 287-3333 Fax: (207) 287-8140 TTY users call Maine Relay 711 Website:www.maine.gov/dental

Frequently Asked Questions:

- **Where do I send my application?** Our mailing address is 143 State House Station, Augusta, Maine 04333- 0143.
- **Can I come to Augusta to pick up my license?** No. A new RDH license with the approved authority will be sent electronically to your email address provided on the application.
- **How can I check the status of my application?** You can check the Board's website: www.maine.gov/dental
- **Can I fax my application?** No.

NOTICES

BACKGROUND CHECK: Pursuant to 5 M.R.S.A. §5301 - 5303, the State of Maine is granted the authority to take into consideration an applicant's criminal history record. The Maine Board of Dental Practice requires a criminal history records check as part of the application process for all applicants.

PUBLIC RECORD: This application is a public record for purposes of the Maine Freedom of Access Law (1 MRSA §401 et seq). Public records must be made available to any person upon request. This application for licensure is a public record and information supplied as part of the application (other than social security number and credit card information) is public information. Other licensing records to which this information may later be transferred will also be considered public records. Names, license numbers and mailing addresses listed on or submitted as part of this application will be available to the public and may be posted on our website.

SOCIAL SECURITY NUMBER: The following statement is made pursuant to the Privacy Act of 1974 (§7(B)). Disclosure of your Social Security Number Is mandatory. Solicitation of your Social Security Number is solely for tax administration purposes, pursuant to 35 MRSA §175 as authorized by the Tax Reform Act of 1975 (42 USC §405(C)(2)(C)(1)). Your Social Security Number will be disclosed to the State Tax Assessor or an authorized agent for use in determining filing obligations and tax liability pursuant to Title 36 of the Maine Revised Statutes. No further use will be made of your Social Security Number and it shall be treated as confidential tax information pursuant to 36 MRSA §191.

Before you seal the envelope, did you:

- Complete every item on the application including the criminal background disclosure question?
- Sign and date your application?
- Include the required fee(s). Make checks payable to "Maine State Treasurer" or complete the credit card section on the application. DO NOT SEND CASH.
- Make a copy of your application to keep for your records?

STATE OF MAINE
BOARD OF DENTAL PRACTICE

143 State House Station, Augusta, ME 04333-0143

INDIVIDUAL APPLICATION

(Revised 12/2022)

APPLICANT INFORMATION (please print)			
FULL LEGAL NAME	*FIRST*	*MIDDLE INITIAL*	*LAST*
ANY OTHER NAMES EVER USED			
DATE OF BIRTH *mm* / *dd* / *yyyy*		SOCIAL SECURITY NUMBER	
MAILING ADDRESS			
CITY	STATE	ZIP CODE	COUNTY
PHONE ( )	FAX ( )	E-MAIL	

BACKGROUND CHECK and 10 DAY REPORTING NOTICE

Pursuant to 5 MRS §5301 - 5303, the State of Maine, Board of Dental Practice is granted the authority to take into consideration an applicant's criminal history record. In addition, the Board of Dental Practice requires licensees to report to the Board criminal convictions within 10 days.

Board of Dental Practice

Required Fee: $100.00

Please Select License Type:

☐ Independent Practice Dental Hygiene Authority

Office Use Only

1421 - $50.00
1446 - $50.00

Office Use Only

Check # _____
Amount: _____
Cash # _____
License # _____

PAYMENT OPTIONS:

Make checks payable to "Maine State Treasurer" – if you wish to pay by credit or debit card, fill out the following:

NAME OF CARDHOLDER (please print) *FIRST* *MIDDLE INITIAL* *LAST*	
ADDRESS OF CARDHOLDER (please print)	
I authorize the Maine Board of Dental Practice to charge my card the following amount: $ _____ ☐VISA ☐M/C ☐Discover ☐AMEX ☐ I understand that fees are non-refundable	
Card number:	Expiration Date: *mm* / *yyyy*
SIGNATURE	**DATE**

High School Education		
Name of Academic Institution:		
Date Diploma Received:		
Mailing Address:		
City:	State:	Zip Code:

Dental Hygiene Education		
Name of Dental School Attended:		
Mailing Address:		
City:	State:	Zip Code:
Degree Granted:	Date Conferred:	

National Dental Hygiene Examination
Did you successfully pass the national examination? Circle one: Yes or No
Date Taken:

Regional Examination
Did you successfully pass a regional examination? Circle one: Yes or No
Name of Examination:
Date Taken:

Current or Intended Place of Employment		
Name of Employer:		
Mailing Address:		
City:	State:	Zip Code:
Dates:		

Previous Employment List in chronological order all professional experience including full work history.			
Dates	Name of Practice	Address	Name of Supervising Dentist

Continuing Education Activities Please list continuing education activities that you have completed during the past two years prior to this application.		
Date	Title of Activity	Hours Earned

Credentialing History

Have you ever held a professional license/certification/registration in this or any other state/country?

[ ] **YES** [ ] **NO**

If yes:

Profession	License #	State/Country	Date Issued	Expiration Date

Licensure / Disciplinary Questions

The following questions must be answered. If you circle "YES" to any question numbered 1 through 18, then please provide additional information such as a written explanation regarding the disclosure, along with additional documentation relevant to the disclosure.

1. Have you ever submitted an application for a professional or occupational license, certification, registration, or permit to any authority, other than the Maine Board of Dental Practice, that was not approved or that was approved subject to a condition, limitation, or restriction?

   YES NO

2. Has any professional or occupational licensing, registration, or certifying authority, other than the Maine Board of Dental Practice, ever disciplined or otherwise imposed any sanctions, fines, probation, limitations, or restrictions on any license, certification, registration, or permit held by you?

   YES NO

3. Have you ever entered into any type of settlement agreement with any professional or occupational licensing, registration, or certifying authority other than the Maine Board of Dental Practice?

   YES NO

4. Are you aware of any complaints filed with any professional or occupational licensing, registration, or certifying authority, other than the Maine Board of Dental Practice, against any license, certification, registration, or permit held by you, for which you have not received a notice of final dismissal?

   YES NO

5. Are you aware of any investigations or inquiries undertaken by any professional or occupational licensing, registration, or certifying authority, other than the Maine Board of Dental Practice, that involve, to any extent, any license, certification, registration, or permit held by you, for which you have not received a notice of final closure or dismissal?

   YES NO

6. Have your practice privileges ever been restricted?

   YES NO

7. Have you ever left a dental licensing jurisdiction, other than the Maine Board of Dental Practice, while a complaint or allegation was pending?

   YES NO

Licensure / Disciplinary Questions (Continued)

8. Have you ever received a sanction from the Center for Medicare and Medicaid Services or any state Medicaid program?

   YES NO

9. Have you ever rendered any dental services illegally?

   YES NO

10. Are you currently dependent on the use of alcohol or habituating drugs?

    YES NO

11. Are you currently engaged in the illegal use of drugs or misuse of any drugs?

    YES NO

12. Are you currently participating in a substance abuse and/or alcohol or drug treatment program, or have you been diagnosed with a substance abuse disorder that in any way currently affects or limits your ability to practice safely and in a competent and professional manner?

    YES NO

13. Do you currently use any chemical substance(s), including alcohol or drugs, which in any way impairs or affects your ability to practice your dental profession with reasonable skill and safety?

    YES NO

14. Do you have or have you ever been diagnosed with or treated for a medical, mental, physical, emotional, nervous, or behavioral disorder or condition that in any way currently limits or impairs your ability to practice safely or to function as a dental professional?

    YES NO

15. Have you ever asserted any condition or impairment as a defense or in mitigation of, or as an explanation for your actions in the course of any administrative or judicial proceeding or investigation; any inquiry or other proceeding; or any proposed termination action (educational, employer, government agency, professional organization, or licensing authority)?

    YES NO

16. Have you been named in any lawsuit involving your practice as a dental professional that was adjudicated to any degree in favor of the other party?

    YES NO

Licensure / Disciplinary Questions (Continued)

17. Have you been named in any lawsuit involving your practice as a dental professional that was settled by the parties?

YES NO

18. Are you currently in default on payment of student loans?

YES NO

Maine Statutes and Rules

19. Have you read the statutes and rules governing dental practices in Maine?

YES NO

Affidavit of Applicant

I have read and completed this application and attest that all information is true to the best of my knowledge. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for denial, suspension or revocation of my license to practice dental hygiene in the state of Maine.

I hereby authorize all hospitals, institutions or organizations, personal physicians, employers (past and present), business and professional associations (past and present), and all government agencies and instrumentalities (local, state, federal or foreign) to release to the Maine Board of Dental Practice, my references and information, files, or records requested by the Board in connection with processing of this application. I hereby authorize the Maine Board of Dental Practice to use photocopies of this authorization and waiver in lieu of the original.

I further authorize the Maine Board of Dental Practice to release to the organizations, individuals and groups listed above, any information which is material to my application.

Signature of Applicant:_____ Date: _____

VERIFICATION OF LICENSURE

To be completed by applicant prior to mailing to each state in which you now hold or have ever held a license to practice. Please print. (This form may be copied as necessary.)

Applicant
Name: _____

Address: _____

_____

(state) *(zip code)*

License Type/Number: _____ Date Issued: _____

I hereby authorize the Board of Dentistry of the State of _____
to furnish to the Maine State Board of Dental Practice the information requested below.

Applicant Signature: Date:

To be completed by the State Licensing Board verifying the above information. Please complete this section and return to the applicants address above:

LICENSING BOARD OR AGENCY: This is to certify that the above-named was issued:

License # Date issued Date of expiration

Current Status of License: (check all that apply) ❑Active ❑Inactive ❑Lapsed
❑Probation ❑Restricted ❑Suspended ❑Revoked

Disciplinary Action: ❑Yes ❑No

(If yes, please attach a copy of the decision and a detailed explanation for the discipline and a copy of the consent agreement(s) or decision & order(s) issued)

Has this license ever been revoked, suspended, limited, surrendered, restricted, placed on probation, disciplined in any way or is it currently under investigation? ❑Yes ❑No

Signature: _____

Title: _____

State completing this form: _____

Date: _____

(SEAL)

STATE OF MAINE
BOARD OF DENTAL PRACTICE
143 STATE HOUSE STATION
AUGUSTA, ME 04333-0143

Independent Practice Dental Hygiene Clinical Practice Verification Form

Use a separate form for each person verifying experience and for each employment setting.
If more space is needed, attach an additional sheet. Please print clearly.

Applicant Data (To be completed in full by Applicant)		
Name of Licensee:	License Number:	
Mailing Address:		
City:	State:	Zip Code:
Work Telephone:	Original Licensure Date:	
Place of Employment During Clinical Practice:		

Education and Clinical Supervision Hours Qualifications (To be completed in full by Applicant)	
2,000 clinical hours	[ ] RDH clinical supervision hours [ ] RDH w/Public Health clinical supervision hours

I ATTEST THAT ALL OF THE INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE.

Signature of Applicant: _____ Date: _____

Independent Practice Dental Hygiene
Clinical Practice Verification Form

Supervising Dentist Information (To be completed in full by Supervising Dentist)		
Name of Supervising Dentist:	License Number:	
Mailing Address:		
City:	State:	Zip Code:
Work Telephone:	Home Telephone:	

Clinical Practice Information of Applicant* (To be completed in full by Supervising Dentist)	
Total Number of Hours Applicant Worked Per Month	
Total Number of Hours Per Month Supervised Clinical Practice was Provided	
Total Number of Hours Applicant Worked	

Dates the Applicant was Under your Supervision: From_____ (month/day/year) To _____ (month/day/year)

(Note: The supervision must be 2,000 clinical practice hours.)

1. Do you recommend that this applicant be granted the authority to practice dental hygiene independently? [ ] YES [ ] NO If not, please describe why:

_____

_____

_____

_____

I ATTEST THAT ALL OF THE INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE. I ALSO AGREE TO RETURN THIS FORM TO THE LICENSEE FOR MAILING TO THE BOARD OF DENTAL PRACTICE.

Signature of Supervising Dentist: _____ Date: _____