STATE OF MAINE

BOARD OF DENTAL PRACTICE

APPLICATION FOR DENTAL THERAPY AUTHORITY (PROVISIONAL)

- 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: 06/2021

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
- Provisional Dental Therapy Written Practice Agreement Outline (If more than one supervising dentist, then a separate written agreement with each dentist must be submitted.)
- 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

- 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. **Note: This form is required only if you have obtained licensure in another state or jurisdiction since you filed for RDH licensure in Maine.**

- Certificate of Education Form: The Board requires that your dental therapy education be verified by the educational institution and submitted directly to the Board.

- 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. **Faxed or emailed 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. However, if the application is incomplete or the application requires a review by the Board at a scheduled meeting, then application review process may take longer.

- 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.

PROVISIONAL DENTAL THERAPY AUTHORITY

Pursuant to 32 M.R.S. § 18302 sub-§ 29, a "Provisional dental therapist" means a person who is licensed as a dental hygienist and holds a valid authority issued by the Board to practice dental therapy under the supervision of a dentist.

Scope of practice pursuant to 32 M.R.S. § 18377 sub-§1: a provisional dental therapist may perform the following procedures in limited settings, if authorized by a written practice agreement with a dentist licensed in this state:

To the extent permitted in a written practice agreement, a provisional dental therapist may provide the care and services listed in this paragraph only under the direct supervision of the supervising dentist:

- Perform oral health assessments, pulpal disease assessments for primary and young teeth, simple cavity preparations and restorations and simple extractions;
- Prepare and place stainless steel crowns and aesthetic anterior crowns for primary incisors and prepare, place and remove space maintainers;
- Provide referrals;
- Administer local anesthesia and nitrous oxide analgesia;
- Perform preventive services;
- Conduct urgent management of dental trauma, perform suturing, extract primary teeth and perform nonsurgical extractions of periodontally diseased permanent teeth if authorized in advance by the supervising dentist;
- Provide, dispense and administer anti-inflammatories, nonprescription analgesics, antimicrobials, antibiotics and anticaries materials;
- Administer radiographs;
- Perform other related services and functions authorized by the supervising dentist and for which the dental therapist is trained; and
- Provide the care and services listed under a dental hygienist's scope of practice while under the supervision of a dentist.

STANDARD APPLICATION

Pursuant to Board Rules, Chapter 2 – the application materials shall include:

- ☐ Completed and signed Application (pgs. 1-9)
- ☐ Payment of fees: application fee $50.00; practice authority fee $50.00

  Note: All fees can be in one payment.

- ☐ An active dental hygiene license in Maine
- ☐ Verification of a master's degree in dental therapy
- ☐ Verification of passing all sections of the ADEX/CDCA dental therapy clinical examination
- ☐ Written practice agreement pursuant to Board Rules Chapter 2, §§VI(D) with a supervising dentist
- ☐ Verification of licensure form (see application information guide for explanation)

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. Your license will be sent electronically to your email address provided on the application.
- **How can I check the status of my application?** You can check our website:www.maine.gov/dental
- **How far back do I go answering the criminal background question?** Disclose information regardless of timeframe.
- **Can I fax or email 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 06/2021)

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	

CRIMINAL BACKGROUND DISCLOSURE

NOTE: Failure to disclose criminal convictions may result in denial, fines, suspension and/or revocation of a license.

Have you ever been charged, summonsed, indicted, arrested or convicted of any criminal offense, including when those events have been deferred, set aside, dismissed, expunged or issued a stay of execution?

(circle one) NO YES

If yes, enclose a detailed description of what happened (including dates), police report and a copy of the court judgment.

By my signature, I hereby certify that the information provided on this application is true and accurate to the best of my knowledge and belief. By submitting this application, I affirm that the Maine Board of Dental Practice will rely upon this information for issuance of my license and that this information is truthful and factual. I also understand that sanctions may be imposed including denial, fines, suspension or revocation of my license if this information is found to be false.

SIGNATURE **DATE**

Board of Dental Practice

Required Fee: $100.00

Office Use Only

1421 - $50.00
1446 - $50.00

Please Select License Type:

☐ Provisional Dental Therapy Practice Authority

Office Use Only

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

PAYMENT OPTIONS:

Make checks payable to "Maine State Treasurer" - If you wish to pay by credit card, fill out the following:

NAME OF CARDHOLDER (please print) *FIRST* *MIDDLE INITIAL* *LAST*

I authorize the Maine Board of Dental Practice to charge my
☐VISA ☐M/C ☐Discover ☐AMEX the following amount: $_____

Card number: *XXXX-XXXX-XXXX-XXXX* 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:	

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

Dental Therapy Examination
Did you successfully pass all sections of a dental therapy 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/dental therapy 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: _____

STATE OF MAINE

BOARD OF DENTAL PRACTICE

CERTIFICATE OF DENTAL THERAPY PROGRAM COMPLETION

I am applying to practice dental therapy in the state of Maine. The Maine Board of Dental Practice requires verification of my education. This is your authority to release any information in your files directly to the Board at the address below.

THIS SECTION TO BE COMPLETED BY THE APPLICANT.

Applicant's name: _____

Applicant's address: _____

Dates of attendance: from_____to_____

THIS SECTION MUST BE COMPLETED BY THE DEAN, SECRETARY OR REGISTRAR OF THE SCHOOL.

I hereby certify that the above named applicant has completed a dental therapy program.

Name of dental therapy program/school_____

Address of school_____

Dates of attendance: from_____to_____

Degree conferred:_____date conferred: _____

Name & title of school official: _____

Official's signature_____dated: _____

PLEASE PLACE
SCHOOL SEAL HERE

Mail to:

Maine Board of Dental Practice
143 State House Station
Augusta, ME 04333-00143

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, encumbered in any way or is it currently under investigation? ❑Yes ❑No

Signature:_____

Title:_____

State completing this form: _____

Date:_____ (SEAL)

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PROVISIONAL DENTAL THERAPY - WRITTEN PRACTICE AGREEMENT

Pursuant to 32 M.R.S. §18345(2)(F) and Board Rules, Chapter 2, Section VI(D) a dental hygienist seeking to obtain the 2,000 hours of supervised clinical practice to qualify for the dental therapy authority must first file an application for a provisional dental therapy authority and submit a signed, written practice agreement with a supervising dentist to qualify for the authority.

A written practice agreement must include the following:

(1) Name, date and signature of the supervising dentist and provisional dental therapist;

(2) Practice settings and locations where services may be provided;

(3) Any limitations on the services that may be provided by the provisional dental therapist, including the level of supervision required by the supervising dentist;

   A. List the limitations on the services that may be provided by the provisional dental therapist;

   B. List the services that are within the scope of practice of the provisional dental therapist and that are restricted or prohibited by the written practice agreement;

(4) Age and procedure specific practice protocols, including case selection criteria, assessment guidelines and imaging frequency;

   A. Provide a description of age specific protocols;

   B. Provide a description of procedure specific protocols;

   C. Provide a description of case selection criteria;

   D. Provide a description of assessment guidelines;

   E. Provide a description of imaging frequency guidelines;

(5) A procedure for obtaining informed consent and creating and maintaining dental records in accordance with Board Rule Chapter 12 for the patients who are treated by the provisional dental therapist;

(6) A plan for review of patient records by the supervising dentist and provisional dental therapist;

(7) A plan to manage dental and medical emergencies and reporting incidents in accordance with Board Rule Chapter 12 in each practice setting where the provisional dental therapist provides care;

(8) A quality assurance plan for monitoring care provided by the provisional dental therapist, including patient care review, referral follow-up and a quality assurance chart review;

A. Provide a description of the patient care review;

B. Provide a description of the plan for referral follow-up;

C. Provide a description of the quality assurance chart review;

(9) Protocols for administering and dispensing medications authorized under, including the specific conditions and circumstances under which these medications are to be administered and dispensed;

A. The provisional dental therapist may provide, dispense and administer anti-inflammatories, nonprescription analgesics, antimicrobials, antibiotic and anticaries materials within the parameters of the written practice agreement, within the scope of practice of a provisional dental therapist, and with the authorization of the supervising dentist;

B. The written agreement must reflect the process in which the dentist authorizes the prescription, and the provisional dental therapist provides, dispenses and administers these medications;

C. A provisional dental therapist is prohibited from providing, dispensing or administering controlled substances;

(10) Criteria for providing care to patients with specific medical conditions or complex medical histories, including requirements for consultation prior to initiating care;

(11) Criteria for the provisional dental therapist to supervise dental hygienists (no more than 2) and unlicensed dental personnel (no more than 3) in any one practice setting to the extent permitted in a written practice agreement;

(12) Specific written protocols to govern situations in which the provisional dental therapist encounters a patient who requires treatment that exceeds the authorized scope of practice;

A. The supervising dentist must ensure that a dentist is available to the provisional dental therapist for timely consultation during treatment if needed;

B. The supervising dentist shall arrange for another dentist or specialist to provide any services needed by a patient of a provisional dental therapist supervised by that dentist that are beyond the scope of practice of the provisional dental therapist and that the supervising dentist is unable to provide;

C. The supervising dentist is responsible for all authorized services and procedures performed by the provisional dental therapist pursuant to the written practice agreement;

(13) The services and procedures that the provisional dental therapist may provide, including the level of supervision;

A. Protocol for the oral evaluation and assessment of dental disease, and for the formulation of an individualized treatment plan by the provisional dental therapist and authorized by the supervising dentist;

i. The provisional dental therapist shall complete an oral evaluation and assessment of dental disease for the patient;

ii. The provisional dental therapist shall collaborate with the dentist in the formulation and authorization of the individualized treatment plan;

iii. The authorization process may include indirect methods such as standing orders, written prescriptive orders, emergency palliative protocols, teledentistry, additional electronic methods for consultation, and other definitive, non-emergency protocols, all contained within the written practice agreement;

iv. In addition, the authorization process may occur simultaneously with providing dental care by the provisional dental therapist, and within the parameters of the written practice agreement in accordance with the scope of practice of a provisional dental therapist;

v. The provisional dental therapist shall refer patients in accordance with the agreement to another qualified dental or health care professional to receive needed services that exceed the scope of the provisional dental therapist;

vi. The provisional dental therapist shall keep a copy of the written practice agreement and make a copy available to patients of the provisional dental therapist upon request;

B. Protocol for the supervising dentist;

i. The collaborating dentist shall perform the comprehensive oral evaluation, determine the diagnosis(es), and formulate the individualized treatment plan upon referral of the patient by the provisional dental therapist;

ii. The dentist shall collaborate with the provisional dental therapist for the provision of dental care as limited by the provisional dental therapist scope of practice under and level of supervision, and if authorized in advance by the supervising dentist;

iii. The supervising dentist shall keep a copy of the written practice agreement and make a copy available to patients of the provisional dental therapist upon request;

(14) A plan for the provisional dental therapist to conduct urgent management of dental trauma, perform suturing, extract primary teeth and perform nonsurgical extractions of periodontally diseased permanent teeth to the extent permitted in a written practice agreement;

(15) A plan for the provisional dental therapist to perform simple cavity preparations, restorations and simple extractions to the extent permitted in a written practice agreement; and

(16) A plan for the provisional dental therapist to administer local anesthesia and nitrous oxide analgesia to the extent permitted in a written practice agreement.

A separate written practice agreement must be submitted for each collaboration with a supervising dentist. As a condition to renew the provisional dental therapy practice authority, a dental hygienist must submit a current written practice agreement with the Board. **The authority to practice provisional dental therapy may not exceed three years.**

The written practice agreement must be signed and maintained by the supervising dentist and the provisional dental therapist. Revisions to a written practice agreement must be documented in a new practice agreement and filed with the Board within 10 days of the change. Similarly, termination of a practice agreement must be documented and submitted to the Board within 10 days of the change.

The Board may request additional information or clarification for information provided in the written practice agreement.