OHIO STATE DENTAL BOARD

77 South High Street, 17th floor
Columbus, Ohio 43215-6135

Phone: 614-466-2580 · Fax: 614-752-8995
www.dental.ohio.gov

PERMISSIBLE PRACTICES DOCUMENTATION FOR DENTAL HYGIENISTS

THIS FORM AND ALL SUPPORTING DOCUMENTATION MUST BE ATTACHED AND MAINTAINED IN THE DENTAL OFFICE WHERE THE DENTAL HYGIENIST IS PRACTICING THE FOLLOWING DUTIES AND OR PROCEDURES:

- ☐ Administration of intraoral block and infiltration local anesthesia (complete Section 3)
- ☐ Administration of nitrous oxide-oxygen (N_2O-O_2) minimal sedation (complete Section 4)
- ☐ Monitoring of nitrous oxide-oxygen (N_2O-O_2) minimal sedation (complete Section 5)
- ☐ Practice when the dentist is not physically present (complete Section 6)
- ☐ Cardiopulmonary Resuscitation (CPR) certificate (complete Section 7)

YOU MUST HAVE COMPLETED A BASIC LIFE-SUPPORT TRAINING COURSE CERTIFIED BY THE AMERICAN HEART ASSOCIATION, THE AMERICAN RED CROSS OR THE AMERICAN SAFETY AND HEALTH INSTITUTE AND REMAIN CURRENT AT ALL TIMES WHEN PERFORMING ANY OF THE DUTIES/FUNCTIONS OUTLINED IN THIS DOCUMENT.

ALL SECTIONS OF THIS DOCUMENT MUST BE COMPLETED INDICATING THE DUTIES AND/OR FUNCTIONS YOU HAVE BEEN APPROPRIATELY TRAINED/EDUCATED TO PROVIDE. IF YOU DO NOT MEET THE SPECIFIC REQUIREMENTS TO PERFORM THESE DUTIES/FUNCTIONS, CHECK THE APPROPRIATE BOX IN THAT SECTION.

SECTION 1 LICENSE HOLDER INFORMATION

Name: _____ Ohio License #: _____

Other Names Used: _____ EFDA Registration #: _____

_____ OHASP Permit #: _____

SECTION 2 SUPERVISING DENTIST INFORMATION

Name: _____ License #: _____

Name of Practice: _____

Address: _____

_____

City: _____ State: _____ Zip Code: _____

Definition: As supervising dentist, I have evaluated the above-named dental hygienist's skills and I have made a determination that this dental hygienist has received the appropriate training and/or examination requirements for all permissible duties indicated on this form and is competent to perform them. I further attest that the information contained herein is true and accurate to the best of my knowledge and belief.

Name (print): _____ Date: _____

Signature: _____

SECTION 3 — ADMINISTRATION OF INTRAORAL BLOCK AND INFILTRATION LOCAL ANESTHESIA

In order to be allowed to perform this function, you **MUST** be currently certified to perform basic life support through the AHA, ARC, or ASHI. A copy of current AHA, ARC, or ASHI CPR Certification **and** copies of your certificate of completion of a course meeting the requirements for administration of local anesthesia **and** report card **OR** other state authorization and curriculum **OR** other state authorization and attestations from former employers must be attached.

☐ I do not meet the educational/training requirements to perform this function.

☐ I have completed a board-approved course in the administration of local anesthesia as set forth in Ohio Revised Code 4715.231 that was provided by an ADA CODA accredited dental or dental hygiene program **and** I have successfully passed the Commission on Dental Competency Assessments (CDCA formerly known as NERB) Local Anesthesia Examination for Dental Hygienists or the Western Regional Examining Board (WREB) Local Anesthesia Examination (copy of transcript from ADA CODA accredited dental hygiene program or certificate of completion of 29-hour course along with a copy of report card attached).

OR

☐ I am authorized to administer local anesthesia in another state **and** I have completed a course of instruction that is substantially equivalent to the required hours and content of the Board-approved local anesthesia course in Ohio as set forth in Ohio Revised Code 4715.231 (copy of other state authorization and a copy of curriculum attached).

OR

☐ I am authorized to administer local anesthesia in another state **and** within the forty-eight months immediately preceding my application for dental hygiene licensure in Ohio, I have documented twenty-four consecutive months of experience in the administration of local anesthesia in the other authorizing state (copy of other state authorization and copies of attestations from former employers attached).

BOARD-APPROVED COURSE & EXAMINATION

Name of Dental/Dental Hygiene Program: Location (City, State): Date of Graduation:

Name of Local Anesthesia Examination: Date of Completion:

STATE(S) OF LICENSURE

List all states in which you have been licensed to practice and hold or have held authorization to administer local anesthesia.

State:	License #:	Date Issued:	Date Expired:

EMPLOYMENT HISTORY

List all places/dates of employment to demonstrate that you have 24 consecutive months of experience in the administration of local anesthesia. You may make copies of this section if additional employment is required to document sufficient experience.

Name: _____ Phone #: _____

Name of Practice: _____ Dates Practiced: _____

Address: _____ Total Hours: _____

City: _____ State: _____ Zip Code: _____

Name: _____ Phone #: _____

Name of Practice: _____ Dates Practiced: _____

Address: _____ Total Hours: _____

City: State: Zip Code:

SECTION 4 — ADMINISTRATION OF NITROUS OXIDE-OXYGEN (N_2O-O_2) MINIMAL SEDATION

In order to be allowed to perform this function, you MUST be currently certified to perform basic life support through the AHA, ARC, or ASHI. A copy of current AHA, ARC, or ASHI CPR Certification **and** a copy of your certificate of completion of a course meeting the requirements for administration of N_2O-O_2 minimal sedation **OR** college transcript **OR** credential issued by another state must be attached.

☐ I do not meet the educational/training requirements to perform this function.

☐ I have completed a six-hour course in the administration (initiate, adjust, monitor, and terminate) of nitrous oxide-oxygen (N_2O-O_2) minimal sedation through a Permanent Sponsor which met the curriculum requirements set forth in Ohio Administrative Code section 4715-9-01.2 **and** I have successfully passed the written examination and clinical competency provided by the Permanent Sponsor (copy of certificate of completion attached).

OR

☐ I have graduated on or after January 1, 2010 from an ADA CODA accredited dental hygiene program and have completed the equivalent training within the dental hygiene curriculum.

OR

☐ I hold a current dental hygiene license, certificate, permit, registration, or other credential issued by another state for the administration of N_2O-O_2 minimal sedation and the training received was substantially equivalent to the required hours, content and examination requirements in Ohio (copy of other state authorization and a copy of curriculum attached).

COURSE INCLUDING EXAMINATION

Name of Permanent Sponsor:	Location (City, State):	Date of Completion:

Course Title: _____

ADA CODA ACCREDITED DENTAL HYGIENE PROGRAM

Name of ADA Accredited Dental Hygiene Program:	Location (City, State):	Date of Graduation:

STATE OF LICENSURE

List the state in which you have been licensed to practice and hold a certificate, permit, registration or other credential to administer N_2O-O_2 minimal sedation.

State:	License #:	Date Issued:

SECTION 5 — MONITORING OF NITROUS OXIDE-OXYGEN (N_2O-O_2) MINIMAL SEDATION

In order to be allowed to perform this function, you MUST be currently certified to perform basic life support through the AHA, ARC, or ASHI. A copy of current AHA, ARC, or ASHI CPR Certification **and** a copy of your certificate of completion of a course meeting the requirements for monitoring of N_2O-O_2 minimal sedation must be attached.

☐ I do not meet the educational/training requirements to perform this function.

☐ I have completed a six-hour course in nitrous oxide-oxygen (N_2O-O_2) minimal sedation monitoring through a Permanent Sponsor which met the curriculum requirements set forth in Ohio Administrative Code section 4715-11-02.1 **and** I have successfully passed the written examination provided by the Permanent Sponsor (copy of certificate of completion attached).

OR

☐ I have graduated on or after January 1, 2010 from an ADA CODA accredited program and have completed the equivalent training within the curriculum (copy of dental hygiene transcript attached).

COURSE INCLUDING EXAMINATION

Name of Permanent Sponsor: Location (City, State): Date of Completion:

Course Title: _____

ADA CODA ACCREDITED DENTAL HYGIENE PROGRAM

Name of ADA CODA Accredited Program: Location (City, State): Date of Completion:

SECTION 6 PRACTICE WHEN THE DENTIST IS NOT PHYSICALLY PRESENT

In order to be allowed to perform this function, you MUST be currently certified to perform basic life support through the AHA, ARC, or ASHI. A copy of current AHA, ARC, or ASHI CPR Certification **and** a copy of your certificate of completion of a four hour Board-approved course meeting the requirements for identification and prevention of potential medical emergencies must be attached.

☐ I do not meet the educational/training requirements to perform this function.

☐ I have documented one year **and** 1,500 hours of experience in the practice of dental hygiene **and** I have successfully completed a four-hour board-approved course in the identification and prevention of potential medical emergencies through a **Permanent Sponsor**, subsequent to completion of my dental hygiene practice experience (copy of certificate of completion attached).

COURSE

Name of **Permanent Sponsor**: Location (City, State): Date of Completion:

Course Title: _____

EMPLOYMENT HISTORY

Dental hygienists must have at least one (1) year of active practice **and** at least 1,500 hours of experience in the practice of dental hygiene in order to be allowed to perform this function. You may make copies of this section if additional employment is required to document sufficient experience.

Name: _____ Phone #: _____

Name of Practice: _____ Dates Practiced: _____

Address: _____ Total Hours: _____

City: _____ State: _____ Zip Code: _____

Name: _____ Phone #: _____

Name of Practice: _____ Dates Practiced: _____

Address: _____ Total Hours: _____

City: _____ State: _____ Zip Code: _____

Name: _____ Phone #: _____

Name of Practice: _____ Dates Practiced: _____

Address: _____ Total Hours: _____

City: _____ State: _____ Zip Code: _____

Name: _____ Phone #: _____

Name of Practice: _____ Dates Practiced: _____

Address: _____ Total Hours: _____

City: State: Zip Code:

SECTION 7 CARDIOPULMONARY RESUSCITATION (CPR) CERTIFICATE

I certify that I have completed and am current in a cardiopulmonary resuscitation (CPR) course provided by the American Heart Association, American Red Cross, or the American Safety and Health Institute pursuant to Ohio Revised Code 4715.251 and/or Ohio Administrative Code sections 4715-9-01.1, 4715-9-01.2, and 4715-9-01.3 when performing the following:

- Administration of intraoral block and infiltration local anesthesia; and/or
- Administration of nitrous oxide-oxygen (N_2O-O_2) minimal sedation; and/or
- Monitoring of nitrous oxide-oxygen (N_2O-O_2) minimal sedation; and/or
- Practicing while the supervising dentist is not physically present, subject to the guidelines set forth in Ohio Administrative Code section 4715-9-05.

Signature: _____ Date: _____

SECTION 8 HEPATITIS B IMMUNIZATION/INNOCULATION

I certify that I have immunity to or immunization against the hepatitis B virus. Attach one or both of the following supporting documentation:

- Medical documentation reflecting dates of the hepatitis B series acceptable to the Board; and/or
- Surface antibody blood titer with results indicating positive, reactive or levels greater than 9.9.

SECTION 9 ATTESTATION

I have read the information in this form and have indicated truthfully, fully and completely those duties which I have been appropriately trained to provide in my scope of practice as a dental hygienist. I further certify that I have read carefully and understand the law and rules pertaining to the practice of dental hygiene, specifically regarding the aforementioned permissible duties and the education, training, examination and documentation requirements. I fully understand that falsification of any documentation may result in formal action by the Ohio State Dental Board.

Signature: _____ Date: _____

ATTENTION

THIS FORM (PAGES 1-6), ALONG WITH ALL SUPPORTING INFORMATION ATTACHED, SHALL BE MAINTAINED IN THE FACILITY(S) WHERE THE DENTAL HYGIENIST IS WORKING AND BE MADE AVAILABLE IMMEDIATELY UPON REQUEST.

DOCUMENTATION OF COMPLETION OF COURSES AND SUCCESSFUL EXAMINATION RESULTS ARE YOUR PERMANENT RECORD. THE OHIO STATE DENTAL BOARD DOES NOT RECEIVE NOR RETAIN COPIES OF YOUR DOCUMENTATION AND WILL NOT ISSUE CERTIFICATES/LICENSES FOR THESE DUTIES/FUNCTIONS.