



# 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](http://www.dental.ohio.gov)

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## DENTAL HYGIENE LICENSE APPLICATION

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The applicant :

- 1) Must be at least 18 years of age,
- 2) Be a graduate of a dental hygiene school which was accredited at the time of his/her graduation by the American Dental Association (ADA) Commission on Dental Accreditation **AND**,
- 3) Must have **PASSED ALL PARTS** of one of the following examinations based on a conjunctive scoring method: North East Regional Board (NERB), Central Regional Dental Testing Service (CRDTS), Southern Regional Testing Agency (SRTA), or the Western Regional Examination Board (WREB), or passed Ohio's Clinical Examination (no longer available). NERB grades for those who took the examination AFTER January 1979 are on file in the Board office. Those who took the exam PRIOR to that date must obtain a copy of their scores from the North East Regional Board, 8484 Georgia Avenue, Suite 900, Silver Spring, MD 20910, phone (301) 563-3300. Those who took other regional board examinations must contact the exam entity and provide documentation demonstrating that all parts of the examination have been successfully passed based on a conjunctive scoring method; **OR**
- 4) Possess a dental hygiene license in good standing from another state and have been actively engaged in the legal and reputable practice of dental hygiene another state or in the armed forces of the United States, the United States public health service, or the United States department of veterans' affairs for five years immediately preceding application.

If the applicant has not previously been examined on the Ohio State Dental Board (Board) statutes and regulations, the examination is available on our website at [www.dental.ohio.gov](http://www.dental.ohio.gov) under jurisprudence exams. You can also call the Board office at (614) 466-2580, to make arrangements to take the jurisprudence examination, where it is administered Monday through Friday (except holidays) between the hours of 8:00 a.m. and 3:00 p.m. Alternatively, you may make arrangements with your state board, or nearby dental or dental hygiene school to have the examination proctored at their facility. The examination must be taken prior to your application being presented for consideration at a Board meeting. The objective of this memo is to provide you with information regarding the basic licensure process.

No provisions exist under Ohio law for temporary or provisional licensure while your application is being processed. The practice of dentistry or dental hygiene prior to licensure constitutes the illegal practice of dentistry/dental hygiene, a criminal offense.

### **PROCESS OF ELIGIBILITY DETERMINATION AND LICENSURE**

All materials submitted to the Board will be thoroughly examined, and individuals will be contacted regarding the application as the Board deems necessary prior to possible licensure in Ohio. Ohio law sets forth the confidentiality of information generated as part of the application process.

### **LICENSE AND WALL CERTIFICATE**

Upon issuance of an Ohio license number, a letter of notification will be sent to you. **That letter will serve as legal authorization to practice in Ohio**, and will be mailed to you as quickly as possible. This letter will be the **ONLY** proof of licensure you will have until the next renewal period, so please keep it! Upon receipt of the wall certificate, you are expected to frame and display it in a conspicuous place in the office in which you practice the majority of the time.

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## INCOMPLETE APPLICATION

Incomplete applications may be returned to the applicant, delaying the approval process. **PLEASE READ ALL INSTRUCTIONS CAREFULLY. ANSWER ALL QUESTIONS ON THE APPLICATION, AND SUBMIT ALL OTHER REQUESTED INFORMATION WITH YOUR APPLICATION WHENEVER POSSIBLE.**

All questions must be fully answered. Indicate N/A (Not Applicable) where appropriate.

All responses on the application must be typed or legibly printed.

Appropriate sections as indicated must be notarized.

If for any reason additional space is needed for any part of the information requested, use an extra sheet of plain white paper. Enter your last name and initials in the upper right-hand corner. Type only on one side.

**REMINDER:** The Ohio State Dental Board jurisprudence examination on the Dental Practice Act (statutes and regulations) must be taken and passed **before** we submit your application to the Board for consideration.

### APPLICATION PROCESSING TIME

Applications **MUST** be in the Board office **at least 30 days prior to the date of the next scheduled meeting**. The length of time needed to process the application depends directly on how quickly the application is returned to the board; when the next Board meeting is scheduled (the Board meets 8-9 times per year); and whether or not the application has been properly completed. Any errors or omissions on the application or in documentation will greatly delay the processing time. **PLEASE MAKE EVERY EFFORT TO MINIMIZE PHONE CALLS TO THE BOARD OFFICE TO INQUIRE ABOUT THE STATUS OF YOUR APPLICATION. TIME SPENT ANSWERING TELEPHONE INQUIRIES IS TIME LOST FROM PROCESSING APPLICATIONS, AND INEVITABLY RESULTS IN A SLOWING OF THE ENTIRE PROCEDURE FOR EVERYONE.**

### WHAT TO SUBMIT WITH APPLICATION

- A full-color, front-faced bust photograph of the applicant, taken not more than six months prior to application must be attached to this application. **ONLY** application or passport-type photographs are acceptable. Do **NOT** write on the face of the photograph. Full legal name is required.
  - Application fee by check or money order (no cash, please). The check is to be made payable to the Ohio State Dental Board. If your application is to be **REVIEWED** by the Board in an **EVEN-NUMBERED YEAR**, the fee of **\$147.00** is required. If **REVIEWED** in an **ODD-NUMBERED YEAR**, the fee of **\$96.00** is required. **ALL FEES ARE NONREFUNDABLE, EVEN IF THE APPLICATION IS DENIED OR SUBSEQUENTLY WITHDRAWN.**
  - Applicant's National Board "Final Report Card". Xerox copies of this card are not acceptable. The National Board report card is available for a nominal fee from the National Board, phone (312) 440-2678.
  - Original test scores from applicants who have taken CRDTS, SRTA or WREB.
  - A Criminal Records check completed by the Bureau of Criminal Identification and Investigation and must be submitted directly to the Board. Results shall be received by the Board prior to the issuance of a license to practice
  - Social Security Number. (This is required to facilitate reporting to the Federal Healthcare Integrity & Protection Data Bank (42 U.S.C. Section 1320a-7e(b), 5 U.S.C. Section 552a, and 45 C.F.R. pt. 61); and accurate identification under Ohio's child support enforcement law (Section 3123.50, O.R.C.). It also may be used for other investigative/enforcement purposes. Failure to provide this information will delay your licensure.)
  - Certification from dental hygiene college, with seal.
  - A certification letter from each of the state board(s) where applicant holds or has held a license, stating license status and whether or not any discipline has ever been taken, with seal.
  - Proof of immunity to or inoculation against the hepatitis B virus. If there are contraindications to your receiving the hepatitis B inoculations, contact the Board office for a waiver application.
  - Physician's Statement. Examination must have been completed within 6 months.
  - Letters of recommendation from each of the local dental hygiene associations or societies of which you have been a member during the past five years.
  - Affidavit notarized.
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## CRIMINAL RECORDS CHECKS REQUIRED FOR INITIAL LICENSURE

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Section 4715.101 of the Ohio Revised Code requires all individuals applying for a license issued by the Ohio State Dental Board (board) to submit fingerprints for a criminal records check completed by the Bureau of Criminal Identification and Investigation (BCI&I) and the Federal Bureau of Investigation (FBI).

### **INSTRUCTIONS FOR OHIO RESIDENTS**

Applicants residing in Ohio are required to utilize "WebCheck" to electronically submit their fingerprints to BCI&I. The Board will typically receive the results of a criminal records check submitted via "WebCheck" within 7 to 10 business days. In addition to the \$22 BCI&I fee and the \$24 FBI fee, the electronic fingerprinting location may charge its own fee to process the fingerprints. Since the law requires applications for licensure to submit a records check completed by both BCI&I and FBI, you **must** use the services of a "WebCheck" vendor that participates in the "National WebCheck." The Sheriff's offices in all 88 counties participate in the "National WebCheck." A list of other "WebCheck" vendors in Ohio, arranged by county, is available online at: <http://www.ohioattorneygeneral.gov/Services/Business/WebCheck/Webcheck-Community-Listing>. When locating an electronic fingerprinting site on this web page, please note that you **must** use the services of a vendor that has "BCI & FBI" listed after the vendor's name as only these entities participate in "National WebCheck." You need both the BCI&I and FBI records check for initial licensure. By law, the board cannot complete the processing of your application until it receives the background check reports from both these entities.

#### ***Instructions for "WebCheck"***

1. Identify a "WebCheck" vendor that participates in the "National WebCheck" and contact that location for specific instructions.
2. Submit the required fee directly to the "WebCheck" vendor. **DO NOT SEND YOUR FINGERPRINTS OR FEE TO THE BOARD.**
3. Request that the criminal records check results from both BCI&I and FBI be sent directly to:  
Ohio State Dental Board  
77 S High St., 17th Floor  
Columbus, OH 43215-3135
4. List the reason for fingerprinting as: "Required for licensure per ORC 4715.101"

### **INSTRUCTIONS FOR OUT-OF-STATE RESIDENTS**

You must contact a local law enforcement agency to arrange for the required fingerprinting on two (2) fingerprint cards. This can only be accomplished by a law enforcement official who must sign and date the cards to verify the accuracy and authenticity of the prints. Any processing fees required for this service should be paid directly to the involved agency. Reminder: Fingerprints processed from out-of-state locations are processed much slower, up to 3 to 4 months, than electronic fingerprints taken within the State of Ohio. Additional delays can occur if the prints are unreadable or information is not complete. If time is extremely critical, you may want to consider submitting the prints electronically from an Ohio location. Should you choose to come to Ohio for your criminal records check, please see Instructions for Ohio Residents.

#### ***Instructions for completing the Fingerprint Card Process***

1. Complete and send BOTH cards to BCI&I after you have been fingerprinted at a law enforcement agency.
2. Complete all the information above the solid blue lines in BLACK INK.
3. Write clearly, as unreadable cards will be rejected.
4. Do not alter the card or boxes.
5. For the FBI (applicant) card: **Race:** W (White); B (Black); A (Asian); I (American Indian/Alaskan Native American); U (Unknown.) **Eyes:** BLK (black); BLU (blue); BRO (brown); GRN (green); GRY (gray) or XXX (unknown.)
6. Make money order or cashier's check payable to Treasurer, State of Ohio. Submit \$22.00 for the Civilian Background Check and \$24.00 for the FBI Check for a total of \$46.00.

**IMPORTANT: SEND BOTH CARDS AND FEES TO BCI&I, PO BOX 365, 1560 STATE ROUTE 56 SW, LONDON, OHIO 43140 (740-845-2375.) DO NOT SEND CARDS AND FEES TO THE BOARD OFFICE.**

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**Certificate of Dental Hygiene College**

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12. I hereby certify that \_\_\_\_\_ matriculated in \_\_\_\_\_  
Name of Applicant  
School of Dental Hygiene on \_\_\_\_\_, \_\_\_\_\_. He/She attended and successfully completed  
a full course of dental hygiene comprised of \_\_\_\_ years of instruction, graduating on the \_\_\_\_ day of \_\_\_\_\_,  
\_\_\_\_\_. I further certify that I know of no reason why the applicant should not be licensed to practice dental hygiene in  
the State of Ohio.

**SEAL**    Signature of Director \_\_\_\_\_ Date \_\_\_\_\_

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**Jurisdictions in which Applicant Holds/Held License**

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13. I am/was licensed to practice dental hygiene in the following jurisdictions and no others:

Jurisdiction	How Licensed	License No.	Date of Issuance	Years of Practice

14. I have been refused dental hygiene licensure by the following jurisdictions and no others, for the following reasons:  
\_\_\_\_\_  
\_\_\_\_\_

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**Practice History**

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15. If you have been admitted to practice in any jurisdiction, provide the following certification and make a complete statement of all your practice since graduation to date. Include temporary or part-time work. State as to each employment or period of practice. (Use an extra sheet of paper, if necessary.)

A. The periods during which you were employed as a hygienist with the dates. \_\_\_\_\_  
\_\_\_\_\_

B. The address of the offices or places at which you have been employed, and the names and addresses of all employers.  
\_\_\_\_\_  
\_\_\_\_\_

C. The nature of your practice. (If your present practice is limited to a specialty, list the specialty.)  
\_\_\_\_\_

D. The reason for the termination of each employment for dental hygienist. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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**Certificate of Secretary of Board of Dental Examiners of the State in which Applicant is Now Licensed (if other than Ohio)**

16. If you are presently licensed in more than one state, provide the following certification from the last state in which you attained licensure, or the one in which you now practice. (Other states should provide letters of certification.)

I, \_\_\_\_\_ Secretary of \_\_\_\_\_  
 (Official Name of Board)  
 hereby certify that \_\_\_\_\_ was granted state certificate number \_\_\_\_\_  
 to practice dental hygiene in the State of \_\_\_\_\_ on the \_\_\_\_\_ day of \_\_\_\_\_,  
 to the basis of \_\_\_\_\_ examination or \_\_\_\_\_ Criteria Approval.

Acting on behalf of \_\_\_\_\_, I hereby certify to the reputability of the applicant as appears  
 (Official Name of Board)  
 on record in this office, and recommend him/her to the Ohio State Dental Board as a fit and proper person to receive a license. I further certify that I know of no reason why this applicant should not be licensed to practice dental in the state of Ohio.

Date \_\_\_\_\_ Signature of Board Secretary \_\_\_\_\_ **SEAL**

- |  |                              |
|--|------------------------------|
| 17. Have you been entitled to practice in each of the jurisdictions specified under question 13, continuously from the date you first became entitled until the present? If NO, why?   | <input type="checkbox"/> Yes |
|  | <input type="checkbox"/> No  |
| 18. Have you been suspended from practice, reprimanded, censured, or otherwise disciplined or disqualified as a dental hygienist or a member of any profession? If YES, state the dates, the facts, the disposition of the matter and the name and address of the authority in possession of the record thereof. (ATTACH STATEMENTS) | <input type="checkbox"/> Yes |
|  | <input type="checkbox"/> No  |
| 19. A. Have you been convicted of or plead guilty to any felony or misdemeanor? (Exclude all traffic violations other than those involving driving while under the influence of alcohol or other drugs.)? If YES, attach statements giving dates and disposition.  | <input type="checkbox"/> Yes |
|  | <input type="checkbox"/> No  |
| B. Do you have any criminal charges pending against you? If YES, attach statement giving details of the matter and the name and address of the authority in possession of the record thereof.  | <input type="checkbox"/> Yes |
|  | <input type="checkbox"/> No  |
| 20. Have you ever been treated for mental illness on an outpatient basis, or been confined to any sanitarium, hospital or mental institution for the treatment of mental illness? If YES, attach statements, giving full explanation, including name and address of doctor and institution.  | <input type="checkbox"/> Yes |
|  | <input type="checkbox"/> No  |
| 21. Are you engaged in the current illegal use of controlled substances or other habit-forming drugs or alcohol or other chemical substances? If YES, attach statement giving full explanation, dates, places, etc.  | <input type="checkbox"/> Yes |
|  | <input type="checkbox"/> No  |
| 22. Are you currently immune to, or have you received inoculation against the hepatitis B virus? If YES, attach documentary evidence of same. If NO, you are required to submit proof of immunity to or inoculation prior to commencing patient contact.   | <input type="checkbox"/> Yes |
|  | <input type="checkbox"/> No  |
| 23. Do you have a physical or mental condition which could affect your ability to practice your profession competently?  | <input type="checkbox"/> Yes |
|  | <input type="checkbox"/> No  |
| 24. Why are you applying for licensure in the state of Ohio?   |                              |

**Medical Report**

25. I, \_\_\_\_\_, a duly licensed physician/nurse practitioner in the state of \_\_\_\_\_, have this day examined \_\_\_\_\_, and my medical examination reveals that to the \_\_\_\_\_  
 Name of Applicant

best of my knowledge, the applicant is not dependent on narcotic drugs or alcohol. Moreover, I find that the applicant has no physical or mental DISABILITIES except: \_\_\_\_\_. The examination was made in \_\_\_\_\_, state of \_\_\_\_\_, on the \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_.

Signature of physician \_\_\_\_\_

26. Are there any unsatisfied judgments against you? If YES, attach statement giving amounts, dates and the nature of the judgement, and the reason for non-payment?  Yes

No

27. Give the name and location of each dental hygiene association of which you have been a member during the preceding five years.

28. Do you intend to reside in Ohio? If NO, where is your intended place of residence?

Yes

No

**Affidavit**

29. STATE OF \_\_\_\_\_ )

SS.

COUNTY OF \_\_\_\_\_ )

I have carefully read the questions in the foregoing application and have answered them truthfully, fully and completely, without mental reservation of any kind.

I fully understand that failure to make a full disclosure of any fact or information called for may result in the denial of my application.

I hereby authorize all educational institutions, governmental agencies and instrumentalities, my references, employers and business and professional associates (past and present), to release to the Ohio State Dental Board any information, files or records requested by the Board in connection with the processing of this application.

I hereby WAIVE all provisions of law forbidding any physician or other person who has attended or examined me, or who may hereafter attend or examine me, from disclosing any knowledge or information which he/she thereby acquired, and I hereby consent that he/she may disclose such knowledge or information to the Ohio State Dental Board.

I hereby certify that I have read carefully and understand the law and rules pertaining to the practice of dental hygiene.

Being duly sworn, \_\_\_\_\_ says that he/she is the person referred to in this application and that the foregoing statements are true in every respect, and that the attached photograph is a true likeness of himself/herself taken within the last six (6) months.

Signature of Applicant \_\_\_\_\_

**S E A L**

Sworn to and subscribed before me this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_

Signature of Notary \_\_\_\_\_

**This space to be COMPLETED by the Ohio State Dental Board**

Date of Examination	Application <input type="checkbox"/> Approved <input type="checkbox"/> Disapproved	License No.	Date
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