



Ohio State Dental Board

77 South High Street, 18th Floor
Columbus, Ohio 43215-6135

Phone #: 614/466-2580
Fax #: 614/752-8995

www.dental.ohio.gov

Limited Teaching License for Dental Hygienists

Ohio law provides that the Ohio State Dental Board (Board) may issue a limited teaching license to an applicant who meets the following conditions:

4715.27

“Upon payment of fifty-eight dollars and upon application endorsed by an accredited dental hygiene school in this state, the board may without examination issue a teacher’s certificate to a dental hygienist, authorized to practice in another state or country. A teacher’s certificate shall be subject to annual renewal in accordance with the standard renewal procedure of sections 4745.01 to 4745.03 of the Revised Code, and shall not be construed as authorizing anything other than teaching or demonstrating the skills of a dental hygienist in the educational programs of the accredited dental hygiene school which endorsed the application.”

Application fees are nonrefundable, even in the event that the application is subsequently denied or withdrawn.

4715-9-04

“An application for a dental hygiene teaching certificate must be certified by the administrator of the dental hygiene school or program where the person is authorized to teach. The application shall contain a statement signed by the applicant as to his knowledge of the dental laws of the state. The certificate granted under the provisions of section 4715.27, of the Revised Code, shall be displayed in a conspicuous place in the institution.

An FBI identification record is required (see enclosed information) or;
An attestation that a FBI identification record has been requested (enclosed).

If the applicant has not previously been examined on the Ohio State Dental Board Statutes and Regulations (a copy of which was included with the application), it will be necessary to call the Board office at (614) 466-2580, to make an appointment to come in and take this examination. The examination must be taken prior to the Board’s consideration of your application (No Exceptions). The examination is given Monday through Friday, except holidays, between the hours of 8:00 a.m. and 3:00 p.m., by appointment only.

The examination can also be taken at a dental or dental hygiene school in your area, or at the office of the state board where you are currently practicing. You must make arrangements for someone to proctor the examination, and notify us of the name and address of the person providing this service, so that we may forward the exam materials to them.

If you have any questions concerning these instructions, please do not hesitate to call the board office.

Information on FBI Background Checks

Required for initial applications for licensure as a dentist, dental hygienist, dental assistant radiographer and limited teaching license, and for all reinstatement applications.

To obtain a civilian background check, please submit a written request for an FBI Identification Record. This request **must include a letter indicating the reason for the request** (*ex: licensure application*), **a signature and a current fingerprint card**. The FBI charges a fee of \$18.00 made payable by a **money order or certified check only** to the Treasury of the United States.

The Fingerprint card must include the following:

- Name
- Date of Birth
- Descriptive information
- All ten (10) rolled impressions
- The plain impressions including the thumbs
- The fingerprint card must be current (18 months)
- Fingerprint impressions must be black permanent fingerprint ink.

If a fingerprint card was not included in the application packet, one may be obtained at the FBI website at <http://www.fbi.gov/hq/cjisd/PDF/fpcardb.pdf>. You may then print the paper copy and submit that for fingerprinting. ***The fingerprints must be taken by a law enforcement agency.***

ALL INFORMATION MUST BE SUBMITTED DIRECTLY TO THE FBI AT:

FBI, Criminal Justice Information Services (CJIS) Division
ATTN: SCU, Mod. D-2
1000 Custer Hollow Road
Clarksburg, WV 26306

Note: The Board did not anticipate the length of time applicants have been required to wait to have the background check completed. The original promise of 2-3 weeks is now realistically 12-18 weeks. It was not the intent of the Board to delay the licensure application process to this extent.

Therefore, for the time being, the Board has agreed to process licensure applications if the application includes the following:

- The application and fees are completed and submitted as required, and the applicant otherwise meets the requirements for the license.
- The question asking whether the applicant has been convicted of a crime is answered in the negative.
- The applicant has proof that he/she has applied for the FBI criminal background check as part of the application process. This proof can be in the form of a receipt, or a copy of the certified check or money order payable to the Treasury of the United States as required for the background check, and the attestation has been submitted

If the above conditions are met, the application will be processed and will not be held up while waiting for the background check information to be completed. The Board will rely upon the statement of the applicant that there is no criminal record, coupled with the fact that a FBI check has been requested, in assessing the good moral character requirement. If the background check comes back indicating that in fact the applicant does have a criminal record, the licensee will then be subject to potential Board discipline for falsification of the application and/or conviction of a crime pursuant to Section 4715.30 of the Ohio Revised Code.



ATTESTATION

I attest that pursuant to the instructions for application as required by the Ohio State Dental Board (Board), I have requested that an FBI Identification record be sent to the Board as part of the application process. The request was made on (date)_____.

Please check all that apply:

- I have not been convicted of or plead guilty to any felony and/or misdemeanor including driving while under the influence of drugs or alcohol.
- I have no misdemeanor and/or felony charges pending.

OR:

- I have been convicted of or plead guilty to any felony and/or misdemeanor including driving while under the influence of drugs or alcohol **and** proper documentation has been provided to the Board.
- I have misdemeanor and/or felony charges pending and proper documentation has been provided to the Board.

As proof of sending the FBI Identification record request I have included the following:

- Receipt from the law enforcement agency who recorded all ten rolled impressions on the fingerprint card.
- Copy of the certified check or money order made payable to the Treasury of the United States as required for the FBI Identification Record.

Printed Name

Signature of Applicant

Date

Certificate of Director or Dental Hygiene School Granting Diploma or Certificate

12. I hereby certify that _____ matriculated in _____
Name of Applicant
Dental College on _____, _____. He/She attended and successfully completed
a full course in dental hygiene comprised of _____ years of instruction, graduating as a dental hygienist on the _____
day of _____, _____. I further certify that I know of no reason why the applicant should not be
granted a limited teaching license in the State of Ohio.

SEAL Signature of Dean _____ Date _____

Jurisdictions in which Applicant is Licensed

13. I am 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 licensure by the following jurisdictions and no others, for the following reasons:

Practice History

15. 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 dentist/hygienist, with the dates.

B. The address of the offices or places at which you have been employed or engaged, 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.

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 hygiene in the state of Ohio.

Date _____ Signature of Board Secretary _____ **SEAL**

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|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------|
| 17. Have you been entitled to practice in each of the jurisdictions specified under question 6, 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 now, or have you ever been addicted to, or have you received treatment for, the habitual use of narcotics or alcohol? 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 |

Medical Report

23. I, _____, a duly licensed physician 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 _____

