



STATE OF TENNESSEE  
DEPARTMENT OF HEALTH  
DIVISION OF HEALTH LICENSURE AND REGULATION  
OFFICE OF HEALTH RELATED BOARDS  
665 MAINSTREAM DRIVE  
NASHVILLE, TENNESSEE 37243

TENNESSEE BOARD OF DENTISTRY  
(615) 532-5073 or 1-800-778-4123  
<http://tn.gov/health/topic/Dentistry-board>

## APPLICATION AND INSTRUCTIONS FOR LICENSURE AS A DENTAL HYGIENIST

### I. THE APPLICATION PROCESS

Application, practice, and renewal as dental hygienists is governed by T.C.A. §63-5-101, et. seq. and Rules 0460-01-.01, et. seq.

1. **All application fees are non-refundable.**
2. All documents and fees required to be submitted by you or which must be requested from the appropriate institutions in this application process, must be mailed directly to:

**Tennessee Board of Dentistry  
665 Mainstream Drive  
Nashville, Tennessee 37243**

3. Allow fourteen (14) working days for information mailed to our office to be received and placed in your file. Federal Express or special courier services will not reduce the processing time. Additionally, if Federal Express or special courier services are used you will be responsible for charges incurred.
4. If the application is not complete upon receipt by the Board's administrative office, a deficiency letter will be sent to you by certified mail. The supporting documentation requested in the letter must be received in the Board's administrative office sixty (60) days from the date of the initial deficiency letter. **Files not completed within sixty (60) days will be closed.**
5. It is recommended that you do **not** set a specific date to begin practice as a dental hygienist in Tennessee until you are granted a license by the Tennessee Board of Dentistry.
6. **IT'S THE LAW!** If you change your mailing address, you must notify the Board's Administrative Office, in **writing**, within thirty (30) days. Failure to abide by this law could affect your license, since failure to receive the renewal application does not relieve you of the responsibility for timely renewal.
7. **ANSWER ALL QUESTIONS ON THE APPLICATION. DO NOT LEAVE ANY AREA BLANK. RESPOND "NOT APPLICABLE" or (N/A) TO ALL QUESTIONS THAT DO NOT APPLY!**

**IMPORTANT: You must have a license issued by the Tennessee Board of Dentistry before you may lawfully practice as a Dental Hygienist in Tennessee.**

There are three (3) avenues for licensure as a dental hygienist in Tennessee. Below are definitions of each avenue. Please carefully read and determine the process that is applicable to you.

1. **Examination** - This requirement is applicable to any dental hygienist who has successfully completed one of the following examinations: Southern Regional Testing Agency (SRTA), Northeast Regional Board (NERB), Central Regional Dental Testing Service (CRDTS) or Western Regional Examining Board (WREB), and has not actively practiced for three (3) of the preceding five (5) years in another state. Please refer to Rule 0460-03-.01 and the Board's policy on the ADEX examination for more information.
2. **Criteria Approval** - This requirement allows a dental hygienist who is licensed in another state and has actively practiced for three (3) of the preceding five (5) years to be considered for licensure without taking a regional examination. Any accepted regional examination must never have been failed to qualify by criteria approval. Please refer to Rule 0460-03-.02 for more information.
3. **Limited Educational License** - This process is applicable to a dental hygienist licensed in another state and who will be teaching in a dental hygiene educational institute. This type of license limits the practice location to programs offered by the educational institution. Upon termination of faculty appointment the license is void. This type of licensure requires a special type of application. Please request this application from our office. Please refer to Rule 0460-03-.03 for more information.

## II. CHECKLIST – USE TO COMPLETE YOUR APPLICATION.

**NOTE: All submissions must be executed and dated less than one (1) year before receipt, or they will be rejected by the Board.**

- |   | <u>Done</u> |
|---|-------------|
| 1. Tape to the <u>first</u> page of the application a passport-size photograph of yourself (taken within the last twelve (12) months); <u>then sign the front of the photograph.</u>  | _____       |
| 2. Complete pages 1 through 6 of the application. Sign page 6 of the application <u>in the presence of a Notary</u> ; then, mail all six (6) pages to the Board's Office.   | _____       |
| 3. Paperclip a check or money order in the amount of One Hundred Twenty-Five Dollars ( <b>\$125</b> ), if applying by examination, or One Hundred Seventy-Five Dollars ( <b>\$175</b> ), if applying by criteria, made payable to the Board of Dentistry to the front of the application.   | _____       |
| 4. Request an official transcript from the institution from which you completed your ADA accredited dental hygiene program. The transcript must be mailed <u>directly</u> to the Board of Dentistry.  | _____       |
| 5. If you <b>are</b> or <b>have ever been</b> licensed, certified, registered, or permitted by any state to practice as a dental hygienist (or any other health care professional), you must request a verification from each and every state. The verification must be mailed directly to the Board's Office from the other state(s).  | _____       |
| 6. Request to have your National Board scores forwarded <u>directly</u> to the Board of Dentistry if you did not request Tennessee receive the scores upon graduation. There is a fee for duplicate scores. The scores can be requested online at <a href="http://www.ada.org/prof/ed/testing/nbdhe/index.asp">http://www.ada.org/prof/ed/testing/nbdhe/index.asp</a> or by contacting the Joint Commission on National Dental Examinations · 211 East Chicago Avenue, Suite 600 · Chicago, IL 60611-2637 · 800-232-1694. | _____       |
| 7. Submit two (2) <u>original</u> letters of recommendation <u>on letterhead</u> from dental professionals who can attest to your character as a dental hygienist. These letters must identify the individuals as dental professionals and <b>must be originals. <i>If applying by criteria, the letters of recommendation must be from a Dentist.</i></b>  | _____       |
| 8. If applying by criteria, proof of practice as a dental hygienist in another state for three (3) of the preceding five (5) years must be submitted from previous employers [supervising dentist(s) or office manager(s)]. The letters must indicate the dates of employment and the average number of hours worked per week.  | _____       |

9. Copy the front and back of your current CPR card on a full-sized sheet of paper. The CPR certification must comply with the Board's *Policy: Cardiopulmonary Resuscitation (CPR) Requirements For Dentists, Dental Hygienists, And Dental Assistants* which requires completion of a BLS Healthcare Provider course, or CPR/AED for the Professional Rescuer, or an equivalent course, which provides training for healthcare professionals in CPR and the use of an AED. The course must be conducted in person and include a skills examination on a manikin with a certified instructor. \_\_\_\_\_
10. Attach proof of U.S. or Canadian citizenship or evidence of being legally entitled to live in the U.S. (e.g. copy of birth certificate, voter's registration card, U.S. passport, naturalization papers, or current visa status.) \_\_\_\_\_
11. Please read the instructions on page 4 of the application carefully. You must answer "Yes", "No", or "N/A" to **every** question. **If any of your answers to the "competency questions" on pages 4 and 5 of the application were in the affirmative, please submit a separate document to explain the situation.** In addition to your explanation, the final documents or orders from the issuing states, courts and/or agencies must be submitted. \_\_\_\_\_
12. If you took the Southern Regional Testing Agency (SRTA) examination within the last five (5) years, your scores were automatically sent to the Board of Dentistry and do not need to be requested from SRTA. If you took any other accepted regional examination, you will need to request that the testing agency send your scores directly to the Board's Administrative office. \_\_\_\_\_

**NOTE:** Anyone applying by examination who took any accepted regional examination **more than five (5) years ago** may be required to appear before the Board for an interview at the next regularly scheduled meeting of the Board (normally January, May and September).

To have your scores mailed, please contact SRTA at (757)428-1003 or [www.srta.org](http://www.srta.org), WREB at (602)944-3315 or [www.wreb.org](http://www.wreb.org), NERB at (301) 563-3300 or [www.NERB.org](http://www.NERB.org) or CRDTS at (785) 273-0380.

13. **A criminal background check is required.** For instructions to obtain a criminal background check, go to <http://tn.gov/health/article/CBC-instructions>. \_\_\_\_\_
14. Applicants who have failed the National Board or any regional examination three (3) times must successfully complete a remedial course of post-graduate studies as a school accredited by the ADA before consideration for licensure by the Board. The program director of the post-graduate program must provide written documentation of the content of such course and certify successful completion. \_\_\_\_\_
15. All applicants must complete, sign and have notarized the Declaration of Citizenship form and submit the documents required. The Declaration is available online at <http://tn.gov/assets/entities/health/attachments/PH-4183.pdf>. \_\_\_\_\_

**IT'S THE LAW!** If you change your mailing address, you must notify the Board's Administrative Office, in **writing**, within thirty (30) days. Failure to abide by this law could effect your license, since failure to receive the renewal application does not relieve you of the responsibility for timely renewal.

**Additional certifications that you can add to your license:**

- Administration of Local Anesthesia – see Rule 0460-03-.12 – requires an additional application
- Administration and Monitoring of Nitrous Oxide Certification - see Rule 0460-03-.06
- Prosthetic Function Certification - see Rule 0460-03-.10
- Restorative Function Certification - see Rule 0460-03-.10

Proof of completion of the required education must be submitted. These procedures cannot be performed until the certification is added to your license. Unless the certification course was offered as part of the ADA accredited dental hygiene program you attended, you must be licensed as a dental hygienist before attending the above certification courses. Please see the rule sections mentioned above for additional requirements and restrictions.



## EDUCATIONAL AND EMPLOYMENT INFORMATION

Please provide the following information for all educational institutions you have attended beyond high school. Use the back of this page if you need additional space. Request an official transcript be submitted directly from the ADA accredited educational institution where you completed your dental hygiene program.

From:	To:	Educational Institution	City, State	Degree Earned	Year Graduated
_____/_____/_____	_____/_____/_____	_____	_____	_____	_____
_____/_____/_____	_____/_____/_____	_____	_____	_____	_____
_____/_____/_____	_____/_____/_____	_____	_____	_____	_____
_____/_____/_____	_____/_____/_____	_____	_____	_____	_____

Please complete your entire employment history starting with the most current position first. Use the back of this page if you need additional space.

<u>Company/ Employer:</u>	<u>Address:</u> (Street, City, and State)	<u>Position:</u>	<u>Duties:</u>	<u>Dates</u>	
				<u>From:</u> Mo./Yr.	<u>To:</u> Mo./Yr.
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

## CERTIFICATION INFORMATION

List below **ALL STATES, COUNTRIES, OR PROVINCES IN WHICH YOU HAVE EVER BEEN OR ARE CURRENTLY LICENSED, PERMITTED, OR CERTIFIED** as a Dental Hygienist. Additional pages may be added if necessary. **If this section does not apply, mark N/A.** Request that verification of licensure be submitted directly to the Board's Office from each state.

STATE	LICENSE NUMBER	DATE ISSUED	CURRENT STATUS
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

List below **ALL** states, countries, or provinces in which you hold or have ever held a license, certification, or permit as a health professional other than a Dental Hygienist. Additional pages may be added if necessary. **If this section does not apply, mark N/A.** Request that verification of licensure be submitted directly to the Board's Office from each state.

STATE	PROFESSION	LICENSE NUMBER	DATE ISSUED	CURRENT STATUS
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

	YES	NO
1. Have you taken the National Boards exam?	_____	_____
2. Have you ever previously applied for a dentist, dental hygiene, or dental assisting license in Tennessee?	_____	_____
3. Have you ever taken the Southern Regional Testing Agency (S.R.T.A.) exam?	_____	_____
4. Have you ever taken the Western Regional Examining Board (WREB) exam?	_____	_____
5. Have you ever taken the North East Regional Board (NERB) exam?	_____	_____
6. Have you ever taken the Central Regional Dental Testing Service (CRDTS) exam?	_____	_____

Please circle below which clinical exam you took and indicate the exam site and the date when you successfully completed the examination. If you took more than one clinical examination, please list the information on each.

Clinical Exam(s) Taken:    SRTA    WREB    NERB    CRDTS    Other: \_\_\_\_\_

Exam Site(s): \_\_\_\_\_

Date Exam(s) Taken: \_\_\_\_\_

## COMPETENCY INFORMATION

**PLEASE ANSWER THE FOLLOWING QUESTIONS.** If any answers to the questions in this part are in the **affirmative**, attach an explanation on a separate sheet. **In support of your explanation, the final documents or orders from the issuing states, courts, and/or agencies must be submitted along with this application.** Please respond to **ALL** questions.

For the purposes of these questions, the following phrases or words have the following meanings:

1. **"Ability to practice your profession"** is to be construed to include all of the following:
  - a. The cognitive capacity to make appropriate clinical diagnosis (if necessary), exercise reasoned judgments, to learn, and keep abreast of developments in your profession;
  - b. The ability to communicate those judgments and information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
  - c. The physical capability to perform tasks and procedures required of your profession, with or without the use of aids or devices, such as corrective lenses or hearing aids.
2. **"Medical Condition"** includes physiological, mental or psychological conditions or disorders, such as, but not limited to; orthopedic, visual, speech and/or hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disability, HIV disease, tuberculosis, drug addiction; and alcoholism.
3. **"Chemical substances"** is to be construed to include alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.
4. **"Currently"** does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather, it means recently enough so that the use of drugs or alcohol may have an ongoing impact on one's functioning as a licensee or within the past two (2) years.
5. **"Illegal use of controlled substances"** means the use of controlled substances obtained illegally (e.g. heroin, or cocaine) as well as the use of controlled substances which are not obtained pursuant to a valid prescription or not taken in accordance with the directions of a licensed health care practitioner.

<b>QUESTIONS:</b>	<b>YES</b>	<b>NO</b>
1. Do you currently have a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety?	—	—
a. If yes, are they reduced or ameliorated because you receive ongoing treatment (with or without medications) or participate in a monitoring program?	—	—
b. If you have any limitations or impairments caused by an existing medical condition, are they reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice?	—	—

*[If you receive such ongoing treatment or participate in such a monitoring program, the Board will make an individual assessment of the nature, the severity, and the duration of the risks associated with an ongoing medical condition so as to determine whether an unrestricted license should be issued, whether conditions should be imposed, or whether you are not eligible for licensure.]*

## COMPETENCY INFORMATION CONTINUED

QUESTIONS – Provide an explanation of an affirmative answers	YES	NO
2. Do you currently use chemical substances?	_____	_____
If yes, do they in any way impair or limit your ability to practice medicine with reasonable skill and safety?	_____	_____
3. Are you currently engaged in the illegal use of controlled substances?	_____	_____
If yes, are you currently participating in a supervised rehabilitation program or professional assistance program that monitors you in order to assure that you are not engaged in the illegal use of controlled substances?	_____	_____
4. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, or voyeurism?	_____	_____
5. If you have held or applied for a license or certificate to practice as a Dental Hygienist in any state, country, or province, has or was it ever been denied, reprimanded, suspended, restricted, revoked, otherwise disciplined, curtailed, voluntarily surrendered under threat of investigation, or disciplinary action?	_____	_____
6. If you have ever had staff privileges at any hospital or health care facility have they ever been revoked, suspended, curtailed, restricted, limited, otherwise disciplined, voluntarily surrendered under threat of restriction, or disciplinary action?	_____	_____
7. Have you ever failed a dental hygiene examination? (National Boards, regional or state) If yes, which exam and how many times have you failed? _____	_____	_____
8. Have you ever applied for and been denied a state or federal controlled substance certificate?	_____	_____
9. If you have possessed such a certificate has it ever been revoked, suspended, restricted, or otherwise disciplined, voluntarily surrendered under threat of investigation, or disciplinary action?	_____	_____
10. Have you ever been convicted of a felony or a misdemeanor other than a minor traffic offense?	_____	_____
11. Have you ever been rejected or censured by a dental society?	_____	_____
12. In relation to the performance of your professional services in any profession:		
a. Have you ever had final judgment rendered against you;	_____	_____
b. Have you ever had settlement of any legal action rendered against you; or	_____	_____
c. Are there any legal actions pending against you or to which you are a party?	_____	_____
13. If you have ever held a license or certificate in any health care profession, has it ever been reprimanded, suspended, restricted, revoked, otherwise disciplined, curtailed, voluntarily surrendered under threat of investigation, or disciplinary action?	_____	_____



**APPLICANT: FILL OUT THE FOLLOWING AFFIDAVIT IN THE PRESENCE OF A NOTARY PUBLIC**

**AFFIDAVIT AND RELEASE**

I, \_\_\_\_\_, of \_\_\_\_\_,  
(Applicant's Name) (City) (State)

being duly sworn and identified as the person referred to in this application attests to the truth of each statement made in said application. I further swear that I have read and understand the law and the Rules and Regulations regarding the practice of my profession, which are posted on the Board's Internet site and/or were provided to me by the Board office, and agree to abide by them in the practice as a dental hygienist in the State of Tennessee.

**I HEREBY:**

**SIGNIFY** my willingness to appear to answer such questions as the Board may find necessary, which may include a full Board interview.

**RELEASE** to the Board, its staff, and their representatives, any and all documentation necessary now and in the future to establish my physical and mental capabilities to safely practice as a dental hygienist.

**AUTHORIZE** the Board, its staff, and their representatives to consult with my prior and current associates and others who may have information bearing on my professional competence, character, health status, ethical qualifications, ability to work cooperatively with others, and other qualifications.

**RELEASE** from liability the Board, its staff, and all their representatives and any and all organizations which provide information for their acts performed and statements made in good faith and without the malice concerning my competence, ethics, character, other qualifications, for certification.

**ACKNOWLEDGE** that I, as an applicant for licensure, have the burden of producing adequate information for a proper evaluation of my professional, ethical, and other qualifications, and for resolving any doubts about such qualifications.

**AUTHORIZE** release, use and disclosure of otherwise HIPAA protected health information to the limited extent necessary for my application to receive full consideration up to and including discussion in a public forum should that become necessary.

**THIS CERTIFIES THAT THE INFORMATION SUBMITTED BY ME IN THIS APPLICATION IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF.**

\_\_\_\_\_  
**SIGNATURE** **DATE**

Sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_\_.

\_\_\_\_\_  
**NOTARY PUBLIC** Affix Seal Here

My Commission Expires \_\_\_\_\_