



# State of Utah

## DIVISION OF OCCUPATIONAL & PROFESSIONAL LICENSING

160 East 300 South, P.O. Box 146741  
Salt Lake City, Utah 84114-6741  
Telephone (801) 530-6628  
[www.dopl.utah.gov](http://www.dopl.utah.gov)

### UPGRADE TO DENTAL HYGIENIST WITH LOCAL ANESTHESIA

(\$35.00 Non Refundable Application Fee)

*(Note: Microsoft Word users can fill in the blanks, print the form and save it for their records)*

<b>***Please list your <u>full legal name</u> as it appears on your driver's license, Social Security Card, etc.***</b>				
Last Name:		First Name:		Middle Name:
Social Security Number:    -    -			Maiden Name:	
I certify under penalty of perjury that:				
and	<input type="checkbox"/> I am a citizen of the United States.			
	<input type="checkbox"/> I am a qualified alien as defined in 8 U.S.C., Sec 1641 who is lawfully present in the United States. I understand that I am required to visit DOPL's offices and present a government issued ID bearing my photo and evidence of one, or both of the following: Alien ID Number                      I-94 Number			
	<input type="checkbox"/> I am a foreign national not physically present in the United States. <i>(If you check this item you do not need to respond to the following section.)</i>			
	<input type="checkbox"/> I have a valid Driver License or State Issued ID    State:            Number: <input type="checkbox"/> I do not have a Driver License. I am legally present in the United States, and I understand that the Department of Commerce will verify my legal presence in order to process my application.			
Mailing Address:				
City:			State:	ZIP:
<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth:	Phone #:	E-Mail:	
List all other licenses, registrations, or certifications issued by any state which you now hold or have ever held in any profession. <i>(Use additional sheets if necessary.)</i>				
Profession:		Issuing State:		
License Number:		License Status:	Issue Date:	
Profession:		Issuing State:		
License Number:		License Status:	Issue Date:	
Profession:		Issuing State:		
License Number:		License Status:	Issue Date:	
Profession:		Issuing State:		
License Number:		License Status:	Issue Date:	

**DO NOT WRITE IN THIS SECTION - FOR DIVISION USE ONLY**

License/Certificate Number: \_\_\_\_\_

Date License/Certificate Approved/Denied: \_\_\_/\_\_\_/\_\_\_ by \_\_\_\_\_

Reason for Denial/Other Comments: \_\_\_\_\_

\_\_\_\_\_

Bureau Manager Review: QQ Yes answers or Education or Exam     Approve     Deny

**AFFIDAVIT and RELEASE AUTHORIZATION FOR APPLICANT**

1. I certify under penalty of perjury that I am a United States citizen, a qualified alien as defined in 8 U.S.C. Sec. 1641, or I am lawfully present in the United States.
2. I certify that am qualified in all respects for the license for which I am applying in this application.
3. I certify that to the best of my knowledge, the information contained in the application and its supporting document(s) is free of fraud, forgery, misrepresentation, omission of material fact; is truthful, correct, and complete; discloses all material facts regarding the applicant; and that I will update or correct the application as necessary, prior to any action on my application.
4. I authorize all persons, institutions, organization, schools, governmental agencies, employers, references, or any others not specifically included in the preceding characterization, which are set forth directly or by reference in this application, to release to the Division of Occupational and Professional Licensing, State of Utah, any files, records, or information of any type reasonably required for the Division of Occupational and Professional Licensing to properly evaluate my qualifications for licensure/certification/registration by the State of Utah.
5. I understand that it is the continuing responsibility of applicants and licensees to read, understand, and apply the requirements contained in all statutes and rules pertaining to the occupation or profession for which you are applying, and that failure to do so may result in civil, administrative, or criminal sanctions.

Name: \_\_\_\_\_ Position: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**APPLYING FOR LOCAL ANESTHESIA PERMIT:**

Local Anesthesia Course Name:	
<b>School Where Taken:</b>	Date Completed:
Official verification of your passing score on the WREB Anesthesia Examination. <b>OR</b>	Date Completed:
Documentation of having a current, active license to administer local anesthesia in another state.	State of Active License:

**CPR/BCLS CERTIFICATION**

<input type="checkbox"/> CPR	Source:	Expiration Date:
<input type="checkbox"/> BCLS		

**RECORD OF PROFESSIONAL EXPERIENCE AS A DENTAL HYGIENIST** *(If Applying By Endorsement)*

Please list your dental hygiene work experience for the past 2 years. *(Use additional sheets if necessary.)*


<b>Employer:</b>		Supervisor:	
Mailing Address:	City:	State:	ZIP:
Phone:	Employed From:	To:	
Position and Duties:			
<b>Employer:</b>		Supervisor:	
Mailing Address:	City:	State:	ZIP:
Phone:	Employed From:	To:	
Position and Duties:			
<b>Employer:</b>		Supervisor:	
Mailing Address:	City:	State:	ZIP:
Phone:	Employed From:	To:	
Position and Duties:			

## QUALIFYING QUESTIONNAIRE

**Read thoroughly, and answer the questions. Do not leave any question blank.**

*(Note: If you have formally expunged a criminal record you do not need to disclose that criminal history.)*

<input type="checkbox"/> Yes <input type="checkbox"/> No	1. Have you ever applied for or received a license, certificate, permit, or registration to practice in a regulated profession under any name other than the name listed on this application?
<input type="checkbox"/> Yes <input type="checkbox"/> No	2. Have you ever been denied the right to sit for a licensure examination?
<input type="checkbox"/> Yes <input type="checkbox"/> No	3. Have you ever had a license, certificate, permit, or registration to practice a regulated profession denied, conditioned, curtailed, limited, restricted, suspended, revoked, reprimanded, or disciplined in any way?
<input type="checkbox"/> Yes <input type="checkbox"/> No	4. Have you ever been permitted to resign or surrender your license, certificate, permit, or registration to practice in a regulated profession while under investigation or while action was pending against you by any health care profession licensing agency, hospital or other health care facility, or criminal or administrative jurisdiction?
<input type="checkbox"/> Yes <input type="checkbox"/> No	5. Are you currently under investigation or is any disciplinary action pending against you now by any licensing agency?
<input type="checkbox"/> Yes <input type="checkbox"/> No	6. Have you ever had hospital or other health care facility privileges denied, conditioned, curtailed, limited, restricted, suspended, or revoked in any way?
<input type="checkbox"/> Yes <input type="checkbox"/> No	7. Have you ever been permitted to resign or surrender hospital or other health care facility privileges, while under investigation or while action was pending against you by any licensing agency, hospital or other health care facility, or criminal or administrative jurisdiction?
<input type="checkbox"/> Yes <input type="checkbox"/> No	8. Is any action related to your conduct or patient care pending against you now at any hospital or health care facility?
<input type="checkbox"/> Yes <input type="checkbox"/> No	9. Have you ever had rights to participate in Medicaid, Medicare, or any other state or federal health care payment reimbursement program denied, conditioned, curtailed, limited, restricted, suspended, or revoked in any way?
<input type="checkbox"/> Yes <input type="checkbox"/> No	10. Have you ever been permitted to resign from Medicaid, Medicare, or any other state or federal health care payment reimbursement program while under investigation or while action was pending against you by any licensing agency, hospital, or other health care facility, or criminal or administrative jurisdiction?
<input type="checkbox"/> Yes <input type="checkbox"/> No	11. Is any action pending against you now by Medicaid, Medicare, or any other state or federal health care payment reimbursement program?
<input type="checkbox"/> Yes <input type="checkbox"/> No	12. Have you ever had a federal or state registration to sell, possess, prescribe, dispense, or administer controlled substances denied, conditioned, curtailed, limited, restricted, suspended or revoked in any way by either the federal Drug Enforcement Administration or any state drug enforcement agency?
<input type="checkbox"/> Yes <input type="checkbox"/> No	13. Have you ever been permitted to surrender your registration to sell, possess, prescribe, dispense, or administer controlled substances while under investigation or while action was pending against you by any health care profession licensing agency, hospital or other health care facility, or criminal or administrative jurisdiction?
<input type="checkbox"/> Yes <input type="checkbox"/> No	14. Is any action pending against you now by either the Federal Drug Enforcement Administration or any state drug enforcement agency?
<input type="checkbox"/> Yes <input type="checkbox"/> No	15. Have you been named as a defendant in a malpractice suit?
<input type="checkbox"/> Yes <input type="checkbox"/> No	16. Have you ever had office monitoring, practice curtailments, individual surcharge assessments based upon specific claims history, or other limitations, restrictions or conditions imposed by any malpractice carrier?
<input type="checkbox"/> Yes <input type="checkbox"/> No	17. Have you ever had any malpractice insurance coverage denied, conditioned, curtailed, limited, suspended, or revoked in any way?
<input type="checkbox"/> Yes <input type="checkbox"/> No	18. If you are licensed in the occupation/profession for which you are applying, would you pose a direct threat to yourself, to your patients or clients, or to the public health, safety, or welfare because of any circumstance or condition?
<input type="checkbox"/> Yes <input type="checkbox"/> No	19. Have you ever been declared by any court of competent jurisdiction incompetent by reason of mental defect or disease and not restored?
<input type="checkbox"/> Yes <input type="checkbox"/> No	20. Have you been terminated, suspended, reprimanded, sanctioned, or asked to leave voluntarily from a position because of drug use or abuse within the past five (5) years?
<input type="checkbox"/> Yes <input type="checkbox"/> No	21. Have you ever had a documented case in which you were involved as the abuser in any incident of verbal, physical, mental, or sexual abuse?
<input type="checkbox"/> Yes <input type="checkbox"/> No	22. Are you currently using or have you recently ( <i>within 90 days</i> ) used any drugs ( <i>including recreational drugs</i> ) without a valid prescription, the possession or distribution of which is unlawful under the Utah Controlled Substances Act or other applicable state or federal law?
<input type="checkbox"/> Yes <input type="checkbox"/> No	23. Do you currently have any criminal action pending?
<input type="checkbox"/> Yes <input type="checkbox"/> No	24. Have you pled guilty to, no contest to, entered into a plea in abeyance or been convicted of a misdemeanor in any jurisdiction within the past ten (10) years? Motor vehicle offenses such as driving while impaired or intoxicated must be disclosed but minor traffic offenses such as parking or speeding violations need not be listed.

<input type="checkbox"/> Yes <input type="checkbox"/> No	25. Have you ever pled guilty to, no contest to, or been convicted of a felony in any jurisdiction?
<input type="checkbox"/> Yes <input type="checkbox"/> No	26. Have you, in the past ten (10) years, been allowed to plea guilty or no contest to any criminal charge that was later dismissed ( <i>i.e. plea-in-abeyance or deferred sentence</i> )?
<input type="checkbox"/> Yes <input type="checkbox"/> No	27. Have you ever been incarcerated for any reason in any federal, state or county correctional facility or in any correctional facility in any other jurisdiction or on probation/parole in any jurisdiction?
	<p><b>If you answered “yes” to any of the above questions, enclose with this application complete information with respect to all circumstances and the final result, if such has been reached. If you answered “yes” to Questions 23, 24, 25, 26, 27, 28 or 29 you must submit a complete narrative of the circumstances that occurred for EACH and EVERY conviction, plea in abeyance, and/or deferred sentence. You must also attach copies of all applicable police report(s), court record(s), and probation/parole officer report(s).</b></p> <p><b>If you are unable to obtain any of the records required above, you must submit documentation on official letterhead from the police department and/or court indicating that the information is no longer available.</b></p> <p><b>If you have formally expunged a criminal record as evidenced by a court order signed by a judge, you do not need to disclose that criminal history. Expungement orders must be sent to the Bureau of Criminal Identification and the FBI to enable the expungement to be completed and the criminal history eliminated from the records.</b></p> <p><b>A “Yes” answer does not necessarily mean you will not be granted a license; however, DOPL may request additional documentation if the information submitted is insufficient.</b></p>

## REQUEST FOR VERIFICATION OF LICENSE

*(Use this form to verify licensure from another state, if applicable.)*

### TO BE COMPLETED BY THE APPLICANT:

Complete the first section of the form and submit it to a state in which you are **currently** licensed. Request that the verifying state complete the form and mail it directly to DOPL or return it to you for submission with your application.

Last Name:	First Name:	Middle Name:
Maiden Name:	Social Security Number:     -     -	
Mailing Address:	City:	State:     ZIP:
Date of Birth:	E-Mail:	Date of Graduation:
I am requesting licensure in the <b>State of Utah</b> as a <b>Dental Hygienist</b> .		
I am/have been licensed in your state under the name:		License nr in your state is/was:
I have enclosed the necessary license verification fee in the amount of \$		
Signature of Applicant:		Date of Signature:

### TO BE COMPLETED BY THE VERIFYING AGENCY:

Please furnish the information requested, sign and verify the document, and mail it directly to DOPL, or place the completed form in a sealed envelope and provide it to the applicant in person or by mail. The applicant will include the sealed verification of licensure with his/her Utah application. Thank you.

Name of Verifying State: \_\_\_\_\_

Name of Licensee *(as it appears in verifying state's records)*: \_\_\_\_\_

Classification of License Issued: \_\_\_\_\_

License Number: \_\_\_\_\_ Current Status: \_\_\_\_\_

Original Date of Licensure: \_\_\_/\_\_\_/\_\_\_ Expiration Date: \_\_\_/\_\_\_/\_\_\_

Continuously Licensed:

Yes     No, please explain: \_\_\_\_\_

Licensed By:

Exam, Type: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

Endorsement: from what state? \_\_\_\_\_

Examination Scores: \_\_\_\_\_

Education Required for Licensure: \_\_\_\_\_

Disciplinary Action or Pending Disciplinary Action:

No     Yes, please provide certified copies of all Petitions, Orders, etc.

Signature: \_\_\_\_\_

Title: \_\_\_\_\_

Agency: \_\_\_\_\_

Date: \_\_\_/\_\_\_/\_\_\_

(SEAL)

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# UPGRADE TO DENTAL HYGIENIST WITH LOCAL ANESTHESIA

<b>Application Checklist</b> <i>(Applications with incomplete attachments will not be considered and may be denied.)</i>	
<input type="checkbox"/>	Submit proof of having an active Dental Hygienist license in the State of Utah.
<input type="checkbox"/>	Submit a copy of your current CPR or BCLS “hands on” course certification card.
<input type="checkbox"/>	If you have been licensed in another state, use the “Request for Verification of License” form <i>(attached to this application)</i> , obtain verification of licensure from a state in which you are currently licensed as a dental hygienist. Request that the verifying state complete the form and mail it directly to DOPL or return it to you for submission with your application.
<input type="checkbox"/>	Complete and submit the Qualifying Questionnaire <i>(submit with application)</i>
<input type="checkbox"/>	An official letter from your anesthesia course director documenting your successful completion of a program of training in the administration of local anesthetics accredited by the Commission on Dental Accreditation of the ADA.
<input type="checkbox"/>	Official verification of your passing score on the WREB Anesthesia Examination.
<input type="checkbox"/>	<b>OR</b> Documentation of having a current, active license to administer local anesthesia in another state.
<input type="checkbox"/>	Submit non refundable application fees of \$37.00

1. **Social Security Number:** Your social security number is classified as a private record under the Utah Government Records Access and Management Act. If an SSN is not provided, the application is incomplete and may be denied.
2. **Address of Record:** The address you provide on this application will be your address of record. You are responsible to directly notify DOPL of any change to your address of record.
3. **Laws and Rules:** You are required to understand Utah laws and rules pertaining to your practice. The following laws and rules are available on the Internet at [www.dopl.utah.gov](http://www.dopl.utah.gov):
4. **Acceptable Forms of Payment:** Licensure fees can be paid by check or money order, made payable to “DOPL.” Cash and debit/credit cards (*American Express, MasterCard, and Visa*) are also accepted in person at DOPL’s main office – but not over the telephone.
5. **Mail Complete Application to:**

<b>By U.S. Mail</b>	Division of Occupational & Professional Licensing P.O. Box 146741 Salt Lake City, Utah 84114-6741
<b>By Express Mail or In Person</b>	Division of Occupational & Professional Licensing 1 <sup>st</sup> Floor Lobby 160 E 300 S Salt Lake City UT 84111-2305

6. **Telephone Numbers:** (801) 530-6628  
(866) 275-3675 – Toll-free in Utah