

<i>Official Use Only</i>
Number: _____
Date Approved/Denied: _____
Approved/Denied By: _____

**Upgrade to:  
Dental Hygienist with Local Anesthesia**

**APPLICANT INFORMATION**

**Full Legal Name:** \_\_\_\_\_  
*First Middle Last*

**All Previous Legal Names:** \_\_\_\_\_

**Other DOPL Licenses Held:** \_\_\_\_\_

**SSN:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_ **Gender:**  Male  Female

**Address:** \_\_\_\_\_  
*Street Address (including Apt/Unit/Ste #) and/or PO Box*

\_\_\_\_\_  
*City State ZIP Code*

**Phone:** \_\_\_\_\_ **Email:** \_\_\_\_\_

**Please Select ONE:**

- I am a United States citizen OR a non-citizen of the United States who is lawfully present.
- I am a foreign national not physically present in the United States.
- None of the above, please explain: \_\_\_\_\_

**Drivers License  
or State ID Card:**

\_\_\_\_\_  
*State of Issue License Number Expiration Date*

**NOTE:** If you do not hold a US Drivers License or a US State ID, you must present a legible copy of your current and valid government issued document(s) showing evidence of authorization to work in the United States.

**AFFIDAVIT AND RELEASE**

1. I certify that I am qualified in all respects for the license for which I am applying in this application.
2. I certify that to the best of my knowledge, the information contained in the application and all supporting document(s) are true and correct, 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.
3. I authorize all persons, organizations, governmental agencies, or any others not specifically listed, 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 to properly evaluate my qualifications for licensure/certification/registration by the State of Utah.
4. 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 I am applying, and that failure to do so may result in civil, administrative, or criminal sanctions.
5. I certify that I do not currently pose a direct threat to myself, to my clients, or to the public health, safety or welfare because of any circumstance or condition.
6. I understand that I am responsible to update the Division of any changes relating to my license/certification/registration.

Signature of Applicant: \_\_\_\_\_ Date: \_\_\_\_\_

## QUALIFYING QUESTIONNAIRE

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

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.

1. <input type="checkbox"/> Yes <input type="checkbox"/> No	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?
2. <input type="checkbox"/> Yes <input type="checkbox"/> No	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 professional licensing agency or criminal or administrative jurisdiction?
3. <input type="checkbox"/> Yes <input type="checkbox"/> No	Are you currently under investigation or is any disciplinary action pending against you now by any <i>local, state or federal licensing, enforcement or regulatory agency</i> ?
4. <input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever been declared by any court to be incompetent by reason of mental defect or disease and not restored?
5. <input type="checkbox"/> Yes <input type="checkbox"/> No	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?
6. <input type="checkbox"/> Yes <input type="checkbox"/> No	Have you been terminated, suspended, reprimanded, sanctioned, or asked to leave voluntarily from a position because of drug or alcohol use or abuse within the past five (5) years?
7. <input type="checkbox"/> Yes <input type="checkbox"/> No	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 applicable state or federal laws?
8. <input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever unlawfully used any drugs for which you have not successfully completed, or are not now participating in a supervised drug rehabilitation program, or for which you have not otherwise been successfully rehabilitated?
9. <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you currently have any criminal action pending?*
10. <input type="checkbox"/> Yes <input type="checkbox"/> No	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? *
11. <input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever pled guilty to, no contest to, or been convicted of a felony in any jurisdiction?*
12. <input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever been incarcerated for any reason in any correctional facility ( <i>domestic or foreign</i> ) in any jurisdiction or on probation/parole in any jurisdiction?*

**\*NOTE: Charges that were later dismissed and motor vehicle offenses such as driving while impaired or intoxicated must be disclosed; however, minor traffic offenses such as parking or speeding violations need not be listed.**

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 9,10,11 or 12 you must submit the following for **EACH** and **EVERY** incident:

- Personal account of the incident
- police report(s)
- court record(s)
- probation/parole officer report(s)

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.

## PROFESSIONAL LICENSES

List all other licenses, registrations or certification issued by any state which you now hold or have ever held in any profession. (Use additional sheets if necessary.)

Profession: \_\_\_\_\_ License Number: \_\_\_\_\_

Issuing State: \_\_\_\_\_ License Status: \_\_\_\_\_ Issue Date: \_\_\_\_\_

Profession: \_\_\_\_\_ License Number: \_\_\_\_\_

Issuing State: \_\_\_\_\_ License Status: \_\_\_\_\_ Issue Date: \_\_\_\_\_

## MEDICAL QUALIFYING QUESTIONNAIRE

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

*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.*

1. Have your rights, privileges, and/or participation ever been denied, conditioned, curtailed, limited, restricted, suspended or revoked in any way by:

- Yes  No a hospital or health care facility  
 Yes  No Medicaid, Medicare or any other state or federal health care payment reimbursement program  
 Yes  No the Federal Drug Enforcement Administration or any state drug enforcement agency  
 Yes  No malpractice insurance coverage  
 Yes  No other entity: \_\_\_\_\_

2. Have you ever been permitted to resign or surrender any rights, privileges and/or participation while under investigation or while action was pending against you from:

- Yes  No a hospital or health care facility  
 Yes  No Medicaid, Medicare or any other state or federal health care payment reimbursement program  
 Yes  No the Federal Drug Enforcement Administration or any state drug enforcement agency  
 Yes  No malpractice insurance coverage  
 Yes  No other entity: \_\_\_\_\_

3. Is any action pending against you now by:

- Yes  No a hospital or health care facility  
 Yes  No Medicaid, Medicare or any other state or federal health care payment reimbursement program  
 Yes  No the Federal Drug Enforcement Administration or any state drug enforcement agency  
 Yes  No malpractice insurance coverage  
 Yes  No other entity: \_\_\_\_\_

4.  Yes  No Have you been named as a defendant in a malpractice suit?

5.  Yes  No Have you ever had office monitoring, practice curtailments, individual surcharge assessments based upon specific claims history, or other limitation, restrictions or conditions imposed by any malpractice carrier?

If you answered "Yes" to question 4 you must submit a complete narrative of the circumstances and a National Practitioner Data Bank report outlining all professional liability claims made against your license and any settlements paid by or on your behalf. NPDB website: <http://www.npdb.hrsa.gov>.

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.

## APPLICATION CHECKLIST AND INSTRUCTIONS

This checklist is for your convenience, you do not need to include it with your application.

**NOTE:** Incomplete applications will be denied.

Your application is classified as a public record and may be available for inspection by the public, except with regard to the release of information which is sub-classified as controlled, private, or protected under the Government Records Access and Management Act or restricted by other law.

### ALL APPLICANTS

The following items are required to complete your application:

- \$35.00 non-refundable application processing fee, made payable to "DOPL".
- Supporting documentation for any "yes" answers provided on the qualifying questionnaires. See pages 2 and 3 of the application for more information.
- Copy of your current CPR or BCLS "hands on" course certification.
- Official letter from your anesthesia course director documenting your successful completion of a program in the administration of local anesthetics accredited by the Commission on Dental Accreditation of the ADA.
- Request an official score report or certificate be released to Utah for the WREB, NERB, SRTA or CRDTS Anesthesia Examination.

Submit the above items with your completed application to:

**In person or via express delivery:**

Division of Occupational and Professional Licensing  
Heber M Wells Building, 1<sup>st</sup> Floor Lobby  
160 E 300 S  
Salt Lake City, UT 84111

**US Postal Service:**

Division of Occupational and Professional Licensing  
PO BOX 146741  
Salt Lake City, UT 84114-6741