



Dental Therapist License Application Packet

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Important Social Security Number Information:

If you have a Social Security Number, the law requires you to disclose it on your application for a professional or occupational license. [42 U.S.C. § 666\(a\)\(13\)](#); [RCW 26.23.150](#). It will be used under the state's child support enforcement program to locate individuals for purposes of establishing paternity and establishing, modifying, and enforcing support obligations. You are not required to have or obtain a Social Security Number to apply for or obtain a license from the Department of Health. If you do not have a Social Security Number, you are still eligible to apply for and obtain a credential if you meet the requirements. Please see the [Declaration of No Social Security Number Form](#). Please call the Customer Service Center at 360-236-4700 if you have questions.

In order to process your request:

Mail your application with initial documentation and your check or money order payable to:

Department of Health
P.O. Box 1099
Olympia, WA 98507-1099

Send other documents not sent with initial application to:

Dental Therapist Credentialing
P.O. Box 47877
Olympia, WA 98504-7877

Contact us:

360-236-4700

To request this document in another format, call 1-800-525-0127. Deaf or hard of hearing customers, please call 711 (Washington Relay) or email doh.information@doh.wa.gov.

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Application Instructions Checklist

You should use this application to obtain a Dental Therapy license if you have completed an approved dental therapy education program. The program must be accredited by the American Dental Association Commission on Dental Accreditation (CODA). The program must have included the following curriculum:

(1) Dental therapy education programs must include coursework encompassing the subject areas within the Washington state dental therapy scope of the practice as listed in RCW 18.265.050 including didactic and clinical competency in:

(a) Periodontal scaling and root planing; and

(b) Administration of nitrous oxide analgesia.

(2) Dental therapy education programs whose curriculum does not include the didactic and clinical competency as required in (1), will be accepted if the applicant successfully completes supplemental education approved by the commission.

(a) The commission accepts supplemental education taken from CODA accredited dental, dental hygiene, and dental therapy schools.

(b) Non-CODA education requires commission approval.

(3) The department shall issue a license to any applicant who successfully completed a dental therapist program before September 30, 2022, that was not accredited by the American dental association's commission on dental accreditation but that is determined to be substantially equivalent to an accredited education program and has proof of at least 400 preceptorship hours under the close supervision of a dentist.

Important background check Information: Washington State law authorizes the Department of Health to obtain fingerprint-based background checks for licensing purposes. This check may be through the Washington State Patrol and the Federal Bureau of Investigation (FBI). This may be required if you have lived in another state or if you have a criminal record in Washington State. This would be at your own expense.

If you do not meet the qualification listed above, you may qualify for the limited license. There is a separate limited license application. See the requirements for an limited license on our [website](#).

All information should be printed clearly in ink. It is your responsibility to submit the required forms.

☐ **Application Fee.** This fee is non-refundable. You can check the online [fee page](#) for current fees.

☐ **Check if either apply:**
Request for Military Training and Experience Evaluation
Spouse or Registered Domestic Partner of Military Personnel

☐ **1. Demographic Information:**
Social Security Number: You must list your social security number on your application. You are not required to have or obtain a Social Security Number

to apply for or obtain a license from the Department of Health. Please see the [Declaration of No Social Security Number Form](#). Please call the Customer Service Center at 360-236-4700 if you do not have one.

National Provider Identifier Number (NPI): The National Provider Identifier (NPI) is a standard unique identifier for health care professionals available from the Federal Centers for Medicare and Medicaid Services. The NPI is a 10 digit numeric identifier. If you have a NPI number, provide this on your application.

Legal Name: List your full name: first, middle, and last.

Definition of legal name: “Legal name” is the name appearing on your official certificate of birth or, if your name has changed since birth, on an official marriage certificate or an order by a court. The court must have the legal authority to change your name. We may ask you to prove your legal name. If you use any name other than your legal name on this form, your application may be denied.

Birth date: Provide your month, day and year of birth.

Address: List the address we should use to send any information about your license. Be sure to include the city, state, zip code, county, and country. This will be your permanent address with the Department of Health until we have been notified of a change. See [WAC 246-12-310](#).

Phone, Fax and Cell Numbers: Enter your phone, fax and cell numbers, if you have them.

Email: Enter your email address, if you have one.

Other Name(s): Indicate whether you are known or have been known under any other names. If you have a name change, you must notify the Department of Health in writing. You must include proof of this change. See [WAC 246-12-300](#).

☐ **2. Personal Data Questions:**

All applicants must answer the same personal data questions. They are focused on your fitness to practice the essential skills of this profession.

If you answer “yes” to any questions in this section, you must provide an appropriate explanation. You must also provide the documentation listed in the note after the question. If you do not provide this, your application is incomplete and it will not be considered.

- Question 5 includes misdemeanors, gross misdemeanors and felonies. You do not have to answer yes if you have been cited for traffic infractions. You can get copies of court records through the county courthouse where the conviction, plea, deferred sentence, or suspended sentence was entered.
- If you have been granted certificate(s) of restoration of opportunity, please provide a certified copy of each certificate.
- Another jurisdiction means any other country, state, federal territory, or military authority.

☐ **3. Education:**

List in date order, most recent to later, all of your educational preparation and post-graduate training. Attach additional completed pages if you need more space.

Transcripts: Graduation from an American Dental Association Commission on Dental Accreditation (CODA) dental therapist education program is the approved education for licensure. Have your school send official school transcripts directly to the Department of Health.

☐ **4. Experience:**

List in date order, most recent to later, all of your professional experience and practice from date of graduation from professional college. Attach additional completed pages if you need more space.

☐ **5. Examination:**

Select all the Dental Therapy examinations you have taken. The following examinations are the approved examinations for license.

- Central Regional Dental Testing Services (CRDTS);
- American Dental Examiners (ADEX); or
- Any other examination that the commission determines as substantially equivalent
- Washington State Drug and Law exam

☐ **6. Other License, Certification, or Registration:**

List all states, including Washington, where credentials are or were held. You must also print the [Verification Form](#) and provide it to each state or jurisdiction that you have listed, requesting that they complete and submit the form directly to the Department of Health. An out of state credential verification form must be resubmitted if it has been over six months since it was last received. Attach additional pages if you need more space.

☐ **7. Applicant's Attestation:**

You must sign and date this for us to process the application.

For Spouses and Registered Domestic Partners of Military Personnel Being Transferred or Stationed in Washington:

Under state law, if you are the spouse or state-registered domestic partner of a servicemember of any branch of the U.S. Military, to include Guard or Reserve, and are applying for a health care professional credential in this state, you may be eligible to have the processing of your application expedited to receive your credential more quickly.

Documents to submit with your application should include the following:

- A copy of your spouse's or registered domestic partner's military transfer orders to Washington State.
- One of the following:
 - A copy of your marriage certificate to show proof of marriage; or
 - A copy of a state's declaration or registration showing you are in a state registered domestic partnership with a member of the U.S. military.

For Current and Former Servicemembers Requesting Evaluation of Military Training and Experience

Under state law, your military education, training, and experience may count towards attaining certain civilian health care profession credentials in Washington State.

Submitted information will be reviewed by the Department of Health to determine substantial equivalency for meeting the credentialing requirements in this state.

Documents to submit with your health care professional credential application should include the following:

- If applicable, a copy of your DD214 Certificate of Release or Discharge from Active Duty, Member-4 or service 2 copy, or NGB-22 for National Guard.

Please note:

- A copy of your DD214 can be downloaded from the [EBenefits website](#).
- You can request a replacement copy of your NGB-22 on the [National Archives website](#).
- Official Joint Service Transcript (JST) or Community College of the Air Force (CCAF) Transcripts.
Please note:
 - JST can be sent electronically by visiting the [JST website](#) and selecting Washington State Department of Health.
 - CCAF transcripts cannot be sent electronically. See the [CCAF website](#) for transcript information.
- Verification of Military Experience and Training (VMET) or DD Form 2586. See the [DoDTAP website](#).
- If applicable, application for the Evaluation of Learning Experiences During Military Service (DD Form 295). See the [Military Resources website](#).



License Requirements

Thank you for applying to become a licensed dental therapist in Washington State. To expedite the license process, please use the following checklist.

☐ **Verification of Examinations:**

Practical Examinations:

- Central Regional Dental Testing Service (CRDTS) Dental Therapy Examination;
- American Dental Examiners (ADEX); or
- Any other examination that the commission determines as substantially equivalent.

A certification of your scores must be sent directly from CRDTS/ADEX/or the substantially equivalent examination/examiner. If your scores are not available electronically, the department will require you to request scores from the examination company directly.

Note: CRDTS/ADEX may charge a processing fee. Please contact them prior to your request to prevent a delay.

Central Regional Dental Testing Service, Inc. 1725 SW Gage Blvd
Topeka, KS 66604-3333
785-273-0380

ADEX
1304 Concourse Drive, Suite 100
Linthicum, MD 21090
301-563-3300

☐ **Verification of your Washington State Dental Therapist Drug and Law Exam.** The examination includes Dental and Dental Therapy laws and rules for Washington State.

- A minimum score of 90 percent is required.
- Dental Therapy laws and rules are located in RCW 18.265 and WAC 246-819.
- Dental laws and rules are located in RCW 18.32 and WAC 246-817.

☐ **Out-of-State Credential Verification**

A verification/certification from any state you have been credentialed in must be sent directly to the Department of Health. An out of state credential verification form must be resubmitted if it has been over six months since it was last received. Attach additional pages if you need more space.

Requirements for Licensure without exam-Licensed in another State

In addition to meeting all the requirements listed above (Requirements for Dental Therapists) you must meet the following:

- ☐ Pay the credentialing application [fee](#).
- ☐ You have a nonlimited license by examination in another state.
- ☐ You have a current license in another state as a dental therapist or dental health aide therapist credentialed in a state or jurisdiction with substantially equivalent licensing standards and have been licensed for at least two years immediately preceding application and meet all other requirements in RCW 18.130.077.

Note: Some applicants do not qualify for a license without exam-Licensed in another State. However, these same applicants may qualify for the limited license. There is a separate limited license application located on our [website](#).

Other Information

Criminal history checks are conducted for all license applicants. If you answered yes to any of the personal data questions, please submit the appropriate supporting documentation as indicated on the application. If your application is incomplete, you will be mailed a letter regarding the deficiencies.

Note: The application is considered incomplete if requested information is left blank. Write N/A or place a line through section instead of leaving blank.

You cannot practice Dental Therapy until:

- Your license is issued.
- You have a signed practice plan agreement with a Washington State licensed dentist-WAC 246-819-080.
- You have liability insurance-WAC 246-819-090

Date
Stamp
Here

Revenue: 0251040000

Dental Therapy Application

Select if either apply: ☐ Request for Military Training and Experience Evaluation
☐ Spouse or Registered Domestic Partner of Military Personnel

Select One: ☐ License by examination ☐ License without exam - Licensed in another state

1. Demographic Information

Social Security Number (SSN) (If you do not have a SSN, see instructions)	National Provider Identifier Number (NPI) (Enter 10 digit number)	☐ Male ☐ Female ☐ Prefer Not to Answer ☐ X
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Name	First	Middle	Last
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Birth date (mm/dd/yyyy)

Address

City	State	Zip Code	County
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Country

Phone (enter 10 digit #)	Fax (enter 10 digit #)	Cell (enter 10 digit #)
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Email address:

Mailing address if different from above address of record

City	State	Zip Code	County
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Country

Note: The mailing and email addresses you provide will be your addresses of record. It is your responsibility to maintain current contact information on file with the department.

Have you ever been known under any other name(s)? ☐ Yes ☐ No

If yes, list name(s):

Will documents be received in another name? ☐ Yes ☐ No

If yes, list name(s):

Dental Therapy School	Year graduated
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Approved dental therapy supplemental education/certification ☐ Yes ☐ No	Date approved
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2. Personal Data Questions

Yes No

1. Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please attach explanation..... ☐ ☐

“Medical Condition” includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, intellectual disabilities, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction, and alcoholism.

If you answered yes to question 1, explain:

- 1a. How your treatment has reduced or eliminated the limitations caused by your medical condition.
1b. How your field of practice, the setting or manner of practice has reduced or eliminated the limitations caused by your medical condition.

Note: If you answered “yes” to question 1, the licensing authority will assess the nature, severity, and the duration of the risks associated with the ongoing medical condition and the ongoing treatment to determine whether your license should be restricted, conditions imposed, or no license issued.

The licensing authority may require you to undergo one or more mental, physical or psychological examination(s). This would be at your own expense. By submitting this application, you give consent to such an examination(s). You also agree the examination report(s) may be provided to the licensing authority. You waive all claims based on confidentiality or privileged communication. If you do not submit to a required examination(s) or provide the report(s) to the licensing authority, your application may be denied.

2. Do you currently use chemical substance(s) in any way which impair or limit your ability to practice your profession with reasonable skill and safety? If yes, please explain. ☐ ☐

“Currently” means within the past two years.

“Chemical substances” include alcohol, drugs, or medications, whether taken legally or illegally.

3. Have you ever been diagnosed with, or treated for, pedophilia, exhibitionism, voyeurism or frotteurism? ☐ ☐

4. Are you currently engaged in the illegal use of controlled substances? ☐ ☐

“Currently” means within the past two years.

Illegal use of controlled substances is the use of controlled substances (e.g., heroin, cocaine) not obtained legally or taken according to the directions of a licensed health care practitioner.

Note: If you answer “yes” to any of the remaining questions, provide an explanation and certified copies of all judgments, decisions, orders, agreements and surrenders. The department does criminal background checks on all applicants.

5. Have you **ever** been convicted, entered a plea of guilty, no contest, or a similar plea, or had prosecution or a sentence deferred or suspended as an adult or juvenile in any state or jurisdiction? ... ☐ ☐

Note: If you answered “yes” to question 5, you must send certified copies of all court documents related to your criminal history with your application. If you do not provide the documents, your application is incomplete and will not be considered.

If you have been granted certificate(s) of restoration of opportunity, please provide a certified copy of each certificate.

To protect the public, the department considers criminal history. A criminal history may not automatically bar you from obtaining a credential. However, failure to report criminal history may result in extra cost to you and the application may be delayed or denied.

2. Personal Data Questions (cont.)

Yes No

6. Have you ever been found in any civil, administrative or criminal proceeding to have:
- a. Possessed, used, prescribed for use, or distributed controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes? ☐ ☐
- b. Diverted controlled substances or legend drugs? ☐ ☐
- c. Violated any drug law? ☐ ☐
- d. Prescribed controlled substances for yourself? ☐ ☐
7. Have you ever been found in any proceeding to have violated any state or federal law or rule regulating the practice of a health care profession? If "yes", please attach an explanation and provide copies of all judgments, decisions, and agreements? ☐ ☐
8. Have you ever had any license, certificate, registration or other privilege to practice a health care profession denied, revoked, suspended, or restricted by a state, federal, or foreign authority? ☐ ☐
9. Have you ever surrendered a credential like those listed in number 8, in connection with or to avoid action by a state, federal, or foreign authority? ☐ ☐
10. Have you ever been named in any civil suit or suffered any civil judgment for incompetence, negligence, or malpractice in connection with the practice of a health care profession? ☐ ☐
11. Have you ever been disqualified from working with vulnerable persons by the Department of Social and Health Services (DSHS)? ☐ ☐

3. Education

List in date order, most recent to later, all of your educational preparation. Attach additional completed pages if you need more space.

Schools Attended Full Name, City and State	Degree Earned	Attendance Dates	
		Start (mm/yyyy)	End (mm/yyyy)

4. Experience

List in date order, most recent to later, all of your professional experience and practice from date of graduation from professional college. Include the month/day/year. Attach additional pages if you need more space.

Name of Business	Total Number of Months	Dates	
		Start mm/yyyy	End mm/yyyy

5. Examination

The examinations listed below are the approved examinations for licensure. Check all that you have taken.

- ☐ Washington State Dental Therapy Jurisprudence examination

Date of exam: _____
(mm/dd/yyyy)

CRDTS Exam:

- ☐ CRDTS – Written exam to include Periodontics, Endodontics, Oral Surgery, Operative Dentistry, Pediatric Dentistry, Emergency Care in Dentistry, SDF.

Date of exam: _____
(mm/dd/yyyy)

- ☐ CRDTS Local Anesthesia Written

Date of exam: _____
(mm/dd/yyyy)

- ☐ CRDTS Permanent Dentition Restorative Typodont

Date of exam: _____
(mm/dd/yyyy)

- ☐ CRDTS Mixed Dentition/Pediatric Exam

Date of exam: _____
(mm/dd/yyyy)

- ☐ CRDTS Periodontal Permanent Dentition Typodont

Date of exam: _____
(mm/dd/yyyy)

ADEX Exam:

- ☐ ADEX-Observed Structured Clinical Exam

Date of exam: _____
(mm/dd/yyyy)

- ☐ ADEX Local Anesthesia written

Date of exam: _____
(mm/dd/yyyy)

- ☐ ADEX Adult Restorative Procedures

Date of exam: _____
(mm/dd/yyyy)

- ☐ ADEX Pediatric Manikin Procedures

Date of exam: _____
(mm/dd/yyyy)

- ☐ ADEX Adult Simulated Patient Treatment Clinical Examination

Date of exam: _____
(mm/dd/yyyy)

6. Other License, Certification, or Registration

List all states where credentials are or were held. Attach additional completed pages if you need more space.

State/ Jurisdiction	Profession	Certificate		Permanent or Temporary	Currently in force
		Year issued	Number		
					☐ No ☐ Yes
					☐ No ☐ Yes
					☐ No ☐ Yes
					☐ No ☐ Yes

7. Applicant's Attestation

I, _____, declare under penalty of perjury under the laws of
(Print applicant name clearly)
the state of Washington the following is true and correct:

- I am the person described and identified in this application.
- I have read [RCW 18.130.170](#) and [RCW 18.130.180](#) of the Uniform Disciplinary Act.
- I have answered all questions truthfully and completely.
- The documentation provided in support of my application is accurate to the best of my knowledge.
- I have read all laws and rules related to my profession.

I understand the Department of Health may require more information before deciding on my application. The department may independently check conviction records with state or federal databases.

I authorize the release of any files or records the department requires to process this application. This includes information from all hospitals, educational or other organizations, my references, and past and present employers and business and professional associates. It also includes information from federal, state, local, or foreign government agencies.

I understand I must inform the department of any past, current or future criminal charges or convictions. I will also inform the department of any physical or mental conditions that jeopardize my ability to provide quality health care. If requested, I will authorize my health providers to release to the department information on my health, including mental health and any substance abuse treatment.

Dated _____ at _____
(mm/dd/yyyy) (City, state)

By: _____
(Signature of applicant)

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Dental Therapy Credentialing
P.O. Box 47877
Olympia, WA 98504-7877
360-236-4700

Dental Therapy Education Verification

Applicant Information:

Name	First	Middle	Last	Date of Birth
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Address

City	State	Zip Code
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To be completed by the dental therapy program:

The student listed above has graduated or successfully demonstrated completion of a dental therapy program accredited or approved by the commission:

_____ on _____
Name of program (mm/dd/yyyy)

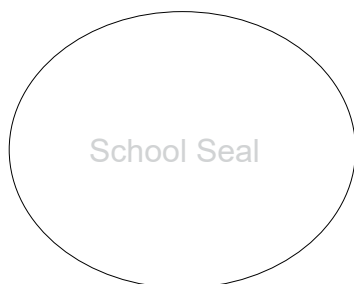
- ☐ The American Dental Association Commission on Dental Accreditation (CODA) for dental therapy.
- ☐ Education approved by The Washington Dental Commission to be substantially equivalent to a CODA accredited dental therapy education program.

Note: If your education has not been previously approved, you will need to submit documentation of substantially equivalent education/coursework to the commission for review.

Please check the answers applicable to this student's successful completion of the following:

Yes No

- ☐ ☐ a. Didactic and clinical competency in the administration of nitrous oxide analgesia;
- ☐ ☐ b. Scaling and;
- ☐ ☐ c. Root planing.



Program Director Name (Please print)

Signature of Program Director

Date

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RCW/WAC and Online Website Links

RCW/WAC Links

[Uniform Disciplinary Act, RCW 18.130](#)

[Administrative Procedure Act, RCW 34.05](#)

[Administrative Procedures and Requirements, WAC 246-12](#)

[Dental Therapist Laws, RCW 18.265](#)

[Dental Therapist Rules, WAC 246 -819](#)

[Dentistry Laws, RCW 18.32](#)

Online

[Dental Therapist Web page](#)