



Dental Hygiene Temporary License First Time Renewal Application Packet

Contents:

- 1. 645-150..... Contents List/SSN Information/Mailing Information 1 page
- 2. 645-151..... Application Instructions Checklist..... 2 pages
- 3. 645-158..... License Requirements 2 pages
- 4. 645-152..... Dental Hygiene Temporary License Renewal Application 2 pages
- 5. 645-164..... Education Verification Nitrous Oxide Analgesia 1 page
- 6. 645-163..... Education Verification Local Anesthesia Endorsement..... 1 page
- 7. RCW/WAC and Online Website Links 1 page

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 Hygiene 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 civil.rights@doh.wa.gov.

(This page intentionally left blank.)



Application Instructions Checklist

You should complete this application to obtain a renewable temporary dental hygiene license. To qualify for licensure you must meet the following requirements:

- You have been issued an initial temporary license.
- Provide verification of successful completion of an approved dental hygiene patient evaluation/prophylaxis clinical dental hygiene examination.
- Provide verification of successful completion of an approved local anesthesia examination.
- Provide verification of didactic and clinical competency in the administration of nitrous oxide analgesia.

All verification documentation must be received directly from the testing agency or educational institution. If the verification is not available electronically from the testing agency, the department will require you to request the scores from the examination company.

If the department has already received any of the required documentation with your initial temporary dental hygiene license, you do not need to resubmit them.

Note: It is recommended that you submit the renewable temporary license application, renewal fee and appropriate expanded functions verification documentation at least 90 days before your initial temporary license expiration date.

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.

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

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

Select if the following applies:
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. Other License, Certification, or Registration.** List all states, including Washington, where credentials are or were held. Attach additional completed pages if you need more space. 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.
- 3. Professional Experience.** In date order, most recent to later, list all your professional work experience since your Washington State credential expired. Attach additional pages if you need more space.
- 4. Disciplinary Action Attestation.** Required by [WAC 246-12-040](#).
- 5. Applicant’s Attestation.** Required to be both signed and dated in order to process the application.

First Time Renewal License Requirements

The initial temporary dental hygiene license is valid for 5 years. The initial temporary license is not renewable. The dental hygiene temporary license can be renewed, but the restorative endorsement cannot. It is recommended that you submit your renewal application and supporting documentation at least 30 days before your initial temporary license expires.

In order to renew for the first time there are documents that you must submit.

Please note: If the department has already received any of the following documents for your initial temporary dental hygiene license, you do not need to resubmit them.

Submit the following:

- Verification of successful completion of an approved dental hygiene patient evaluation/prophylaxis (clinical hygiene) exam.

We only accept the following exams:

- Western Regional Examining Board (WREB) Dental Hygiene Examination if passed after May 8, 1992.
- Central Regional Dental Testing Service (CRDTS) Dental Hygiene Examination if passed after November 1, 2001.
- Commission on Dental Competency Assessments (CDCA) (formally NERB) Dental Hygiene Examination if passed between January 1, 2000 and August 21, 2009, or if passed after March 16, 2018.

- Verification of successful completion of an approved local anesthesia exam.

We only accept the following exams:

- WREB Anesthesia Examination if passed after May 8, 1992.
- WREB Restorative Examination if passed after May 8, 1992.
- CRDTS Anesthesia Examination if passed after October 13, 2017.
- CRDTS Restorative examination if passed after March 7, 2016.

- Verification of successful course completion of didactic and clinical competency in the administration of nitrous oxide analgesia and local anesthesia.

Submit the applicable dental hygiene expanded function education verification form. The form is for either your dental hygiene ADA accredited program or the secretary approved courses. We do accept a combination of verifications.

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.

Other Information

Criminal history checks are conducted for all license applicants. If your renewal application is incomplete, you will be mailed a letter regarding the deficiencies.

- The renewal application is considered incomplete if requested information is left blank. Write N/A or place a line through section instead of leaving blank.
- The initial license will expire on your birthday unless the license is issued within 90 days of your next birthday. See [WAC 246-12-020 \(3\)](#).
- A courtesy renewal notice will be mailed to your address on record. You must keep your address current with us. Any renewal postmarked or presented to the department after midnight on the expiration date is late.

Date
Stamp
Here

Revenue: 0251040000

Dental Hygiene Temporary License First Time Renewal

Please print clearly. It is the responsibility of the applicant to submit or request all required supporting documents be submitted. Failure to do so may result in a delay in processing your application.

Temporary License First Time Renewal Initial Temporary License Number _____

Select if the following applies: Spouse or Registered Domestic Partner of Military Personnel

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)	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Prefer not to answer <input type="checkbox"/> X
---	---	--

Name	First	Middle	Last
------	-------	--------	------

Birth date (mm/dd/yyyy)

Address

City	State	Zip Code	County
------	-------	----------	--------

Country

Phone (enter 10 digit #)	Fax (enter 10 digit #)	Cell (enter 10 digit #)
--------------------------	------------------------	-------------------------

Email address

Mailing address if different from above address of record

City	State	Zip Code	County
------	-------	----------	--------

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):

2. Other License, Certification, or Registration

State/Jurisdiction	Profession	Credential			Method of Credentialing	Currently In Force	
		Type	Number	Year Issued		No	Yes

3. Professional Experience

Type of experience of practice and location	Start (mm/yyyy)	End (mm/yyyy)

4. Disciplinary Action Attestation

I certify no action has been taken by any state or federal jurisdiction or hospital, which would prevent or restrict my right to practice my profession.

I further certify I have not voluntarily given up any credential or privilege or have not been restricted in the practice of my profession in lieu of or to avoid formal action.

APPLICANT'S INITIALS

5. 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)

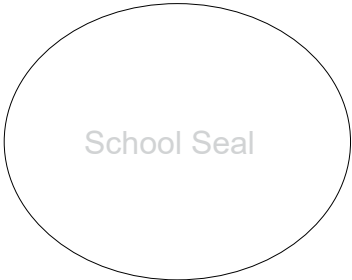
By _____
(Signature of applicant)

(This page intentionally left blank.)

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

Dental Hygiene Expanded Functions Education Verification Local Anesthesia Endorsement Form

Note: this form must be submitted directly from the Dental Hygiene program.

Applicant Information:			
Name First	Middle	Last	Date of Birth
Address			
City	State	Zip Code	
To be completed by the dental hygiene program:			
<p>The student listed above has graduated or successfully demonstrated the following at</p> <p>_____ on _____</p> <p style="text-align: center; margin-left: 100px;">Name of program (mm/dd/yyyy)</p> <p>which is a dental hygiene program accredited or approved by the following:</p> <p><input type="checkbox"/> Expanded functions education program approved by the Secretary of the Department of Health.</p> <p><input type="checkbox"/> The American Dental Association Commission on Dental Accreditation for dental hygiene.</p> <p><input type="checkbox"/> The Commission on Dental Accreditation of Canada (CDAC) for dental hygiene.</p> <p><input type="checkbox"/> Other, please list: _____</p> <p>Please note clinical competency means on live patients.</p> <p>Did the student complete didactic and clinical competency in the administration of injections of local anesthetic, which includes infiltration: ASA, MSA, Nasopalatine, greater palatine. Block: Long buccal, mental, inferior alveolar, and PSA?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <div style="display: flex; justify-content: space-between; align-items: flex-start; margin-top: 20px;"> <div style="text-align: center;">  <p>School Seal</p> </div> <div style="width: 60%;"> <p>_____ Program Director Name (Please print)</p> <p>_____ Signature of Program Director</p> <p>_____ Date</p> </div> </div>			

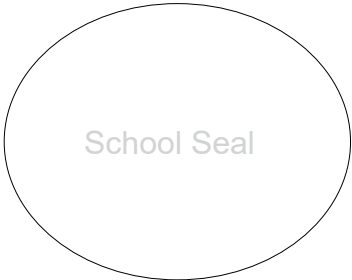
(This page intentionally left blank.)



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

Dental Hygiene Expanded Functions Education Verification Nitrous Oxide Analgesia Form

Note: this form must be submitted directly from the Dental Hygiene program.

Applicant Information:			
Name First	Middle	Last	Date of Birth
Address			
City	State	Zip Code	
To be completed by the dental hygiene program:			
<p>The student listed above has graduated or successfully demonstrated the following at</p> <p>_____ on _____</p> <p style="text-align: center; margin-left: 100px;">Name of program (mm/dd/yyyy)</p> <p>which is a dental hygiene program accredited or approved by the following:</p> <p><input type="checkbox"/> Expanded functions education program approved by the Secretary of the Department of Health.</p> <p><input type="checkbox"/> The American Dental Association Commission on Dental Accreditation for dental hygiene.</p> <p><input type="checkbox"/> The Commission on Dental Accreditation of Canada (CDAC) for dental hygiene.</p> <p><input type="checkbox"/> Other, please list: _____</p> <p>Please note clinical competency means on live patients.</p> <p>Did the student complete didactic and clinical competency in the administration of nitrous oxide analgesia?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <div style="display: flex; justify-content: space-between; align-items: flex-end; margin-top: 20px;"> <div style="text-align: center;">  <p>School Seal</p> </div> <div style="width: 60%;"> <p>_____</p> <p>Program Director or Instructor Name (Please print)</p> <p>_____</p> <p>Signature of Program Director or Instructor</p> <p>_____</p> <p>Date</p> </div> </div>			



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 Hygienist Laws, RCW 18.29](#)

[Dental Hygienist Rules, WAC 246-815](#)

[Dentistry Laws, RCW 18.32](#)

Online

[Dental Hygiene Examining Committee Web page](#)