

**MONTANA BOARD OF DENTISTRY**  
**PO BOX 200513**  
(301 S PARK, 4TH FLOOR - Delivery)  
Helena, Montana 59620-0513  
(406) 444-5711

EMAIL: [DLIBSDLicensingUnitB@mt.gov](mailto:DLIBSDLicensingUnitB@mt.gov) WEBSITE: [www.dentistry.mt.gov](http://www.dentistry.mt.gov)

ILLEGIBLE AND INCOMPLETE APPLICATIONS WILL BE RETURNED  
(Please allow 14 days for processing from the date that the Board has a complete routine application)

**DENTAL HYGIENISTS ARE NOT PERMITTED TO PRACTICE DENTAL HYGIENE IN MONTANA IN ANY MANNER WITHOUT AN ACTIVE MONTANA LICENSE**

**LICENSE REQUIREMENTS:**

**1. LICENSURE BY EXAMINATION:**

- Applicant shall have graduated from an accredited Commission on Dental Accreditation Dental Hygiene School (CODA)
- Applicant shall have passed the National Board Dental Examination
- Applicant shall have passed a Board approved clinical examination within the last 5 years
- Applicant shall pass a Montana Jurisprudence examination
- Applicant shall possess a current CPR/ACLS/PALS certification

**2. LICENSURE BY CREDENTIALING:**

- Applicant shall have graduated from an accredited Commission on Dental Accreditation Dental Hygiene School (CODA)
- Applicant shall have passed the National Board Dental Examination
- Applicant shall have successfully passed a clinical examination for initial licensure
- Applicant shall pass a Montana Jurisprudence examination
- Applicant shall possess a current CPR/ACLS/PALS certification
- Applicant shall verify dental hygiene practice for a minimum of 1000 hours during the two years prior to application

**3. VOLUNTEER LICENSE:**

- Applicant shall have graduated from an accredited Commission on Dental Accreditation Dental Hygiene School (CODA)
- Applicant shall have passed the National Board Dental Examination
- Applicant must have practiced within the last five years or;
  - ✓ Passed a Board approved regional or state examination within the last five years or;
  - ✓ Completed a Board approved clinical competency course or skills assessment analysis
- Applicant shall verify licensure in good standing for at least ten years in Montana, another state or jurisdiction, Canada or the United States Armed Forces
- Applicant shall be retired
- Applicant shall possess a current CPR/ACLS/PALS certification

**4. RESTRICTED NON RESIDENT VOLUNTEER LICENSE (Applicant is not a Montana Resident)**

- Applicant shall have graduated from an accredited Commission on Dental Accreditation Dental Hygiene School (CODA)
- Applicant must hold an active license in good standing in another state
- Applicant cannot receive monetary compensation for services provided under restricted temporary non-resident volunteer license
- Applicant can only work 14 days per license renewal cycle

**5. LIMITED ACCESS PERMIT:**

- Applicant shall have an active, unrestricted Montana dental hygiene license (may apply for a permit when applying for a dental hygiene license)
- Applicant shall certify that they have practiced either:  
a 2,400 clinical hours over the last three years or;  
a a career total of 3,000 hours, with a minimum of 350 hours in each of the last two years
- Applicant shall have current liability insurance
- Applicant shall have 12 additional continuing education credits for the three-year cycle immediately preceding application for the Limited Access Permit
- Applicant shall submit a \$50.00 fee
- Applicant shall possess a current CPR/ACLS/PALS certification

**6. LOCAL ANESTHESIA PERMIT:**

- All applicants applying for a local anesthesia permit shall have passed the Western Regional Examination Board (WREB) local anesthetic examination
- Applicant shall possess a current CPR/ACLS/PALS certification
- Applicant shall either be applying for a Montana license or already be licensed in Montana
- Applicant shall submit a \$20.00 fee
- Applicants applying for a local anesthesia permit by credentialing shall be required to meet the following:
  - ✓ Verification that the applicant has practiced administration of local anesthetic agents within the last five years and passed the Western Regional Examination Board (WREB) local anesthetic examination

	<b><u>Examination Application Fees</u></b>	<b><u>Credentialing Application Fees</u></b>
<b>FEES:</b>	Application Fee - \$100.00	Application Fee - \$100.00
	Jurisprudence Exam Fee - \$85.00	Credentialing Fee - \$75.00
		Jurisprudence Exam Fee - \$85.00
	<b><u>Other Application Fees</u></b>	
	Volunteer Application Fee - \$5.00	
	Limited Access Permit Application Fee - \$50.00	
	Local Anesthesia Permit Application Fee - \$20.00	
	Non Resident Volunteer License - \$10.00	

**\*\*Make check or money order payable to the Montana Board of DENTISTRY  
(Fees can be combined into one check)**

## DOCUMENTS TO BE SUBMITTED FOR AN APPLICATION TO BE CONSIDERED COMPLETE:

### LICENSURE BY EXAMINATION ADDITIONAL DOCUMENTS:

- **National Practitioner Data Bank (NPDB) self-query.** This form can be obtained by calling NPDB at 800-767-6732 or visit [www.npdb-hipdb.com](http://www.npdb-hipdb.com) on the Internet. This form must be mailed directly to the address indicated in the instructions. The results will come to you; upon receipt please send the **unopened** original report to the Board office.
- Copy of Dental Hygiene Diploma,(if a diploma has not been issued, a letter from the dean of the school of dental hygiene attesting to the program of study and that graduation status was attained, may be substituted in lieu of the diploma).
- Official transcripts sent directly from an approved dental hygiene school
- Original National Board Examination Score verification from the Joint Commission on National Dental Examinations. Our staff can access this online through JCNDE. If a verification has not already been requested, you may request one by calling (800) 232-1694, [nbexams@ada.org](mailto:nbexams@ada.org)
- Verifications of successful passage of a Board approved clinical examination.
- License verification(s) sent directly from the state(s) where you have held a license directly to the Board office.
- Two reference letters of moral character (relatives may not be used as references).
- Copy of current CPR, ACLS, or PALS card.
- Check or money order for the appropriate fees.

### LICENSURE BY CREDENTIALING DOCUMENTS:

- **National Practitioner Data Bank (NPDB) self-query.** This form can be obtained by calling NPDB at 800-767-6732 or visit [www.npdb-hipdb.com](http://www.npdb-hipdb.com) on the Internet. This form must be mailed directly to the address indicated in the instructions. The results will come to you; upon receipt please send the **unopened** original report to the Board office.
- Official transcripts sent directly from an approved dental hygiene school
- Original National Board Examination Score verification from the Joint Commission on National Dental Examinations. Our staff can access this online through JCNDE. If a verification has not already been requested, you may request one by calling (800) 232-1694, [nbexams@ada.org](mailto:nbexams@ada.org)  
Verification of passage of a clinical examination.
- Copy of State license(s) that was or is held for any professional licensed occupation in this or any other state.
- License verification(s) sent directly from the state(s) where you have held or hold a license verifying status and any disciplinary action on your license sent directly to the Board office.
- Two reference letters of moral character (relatives may not be used as references).
- Copy of current CPR, ACLS or PALS card.
- Completed Certification of Hours Form (1000 hours of practice within the last two years)
- Check or money order for the appropriate fees

**LIMITED ACCESS PERMIT DOCUMENTS:**

- Complete the Limited Access permit application,
- Copy of current liability insurance.
- Copies of 12 additional CE credits.
- Check or money order for the appropriate fee.

**VOLUNTEER PERMIT DOCUMENTS:**

- Copy of official transcripts from the school, showing graduation from an accredited CODA approved dental school.
- Copy of the National Board Dental Examination showing passage.
- If the applicant has not practiced in the last five years, the applicant shall submit:
  - ✓ Copy of a clinical examination that has been passed in the last five years; or
  - ✓ Verification that the application has taken an approved clinical competency course or skills assessment analysis.
- Completed Volunteer License Statement form included in application packet.
- Copy of CPR, ACLS, or PALS card.
- Check or money order for the appropriate fee.

**RESTRICTED NONRESIDENT VOLUNTEER DOCUMENTS**

- Copy of official transcripts from a dental hygiene program or school accredited by CODA
- License verification(s) from all states where licensee currently holds a license
- Completed Volunteer License Statement included in application packet

**NOTE: ALL DOCUMENTS NOT IN ENGLISH MUST BE ACCOMPANIED BY  
CERTIFIED TRANSLATIONS**

**CLINICAL EXAM INFORMATION:**

A Board approved clinical examination must be successfully passed. For licensure by examination, exams are valid for five years.

**The Board accepts the following clinical examinations:**

**CITA - COUNCIL OF INTERSTATE TESTING AGENCIES 1- 866-678-9795  
www.citaexam.com**

**CRDTS - CENTRAL REGIONAL DENTAL TESTING SERVICE (785) 273-0380  
www.crdts.org**

**CDCA – THE COMMISSION ON DENTAL COMPETENCY ASSESSMENTS (FORMALLY NERB -  
NORTH EAST REGIONAL BOARD OF DENTAL EXAMINERS, INC) (301) 563-3300  
www.cdcaexams.org (www.nerb.org)**

**SRTA - SOUTHERN REGIONAL TESTING AGENCY INC (757) 318-9082 www.srta.org**

**WREB - WESTERN REGIONAL EXAMINING BOARD (602) 944-3315 www.wreb.org**

**IMPORTANT NOTICE: IF YOU ARE TAKING OR HAVE TAKEN THE ADEX DENTAL HYGIENE  
EXAM OFFERED BY ONE OF THE APPROVED TESTING AGENCIES, PLEASE NOTE THE  
ADEX EXAM HAS BEEN APPROVED BY THE BOARD RETROACTIVE TO JANUARY 1, 2013.  
HOWEVER, THE BOARD HAS DETERMINED YOU MUST TAKE ALL SECTIONS OF THE ADEX  
EXAM INCLUDING THE PERIODONTICS SECTION.**

Application for clinical examination must be filed directly with the testing entity at the above address. The testing entity establishes the dates and testing sites. The clinical examination must be passed prior to making an application for licensure by examination in the State of Montana. Exam results are valid for five years.

**THE ABOVE TESTING ENTITIES ARE NOT LICENSING AGENCIES**

The Board also accepts clinical exams given by the following States:

California

Nevada

Please contact the State directly for exam results or information

**APPLICATION PROCEDURES**

- When a routine application file is complete, it will be processed and considered by Board staff for permanent licensure. The applicant may be notified if additional information is required or if the applicant will be required to appear before the Board during a regularly scheduled Board meeting.
- If the application is considered a non-routine application, there may be a delay in processing of the application. You may be requested to provide additional information, or make a personal appearance before the Board during a regularly scheduled Board meeting. Non-routine applications may take up to 120 days to process.
- All verifications of licensure must be sent directly from each state board in which the applicant is currently or has ever been licensed. Please make copies of the attached verification request form as needed. Some states may charge a fee for verifications. Contact each state board prior to sending the request.
- Keep the Board office informed at all times of any address changes, changes in license status and complaints or proposed disciplinary action. This is essential for timely processing of applications and subsequent licensure.

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#### **JURISPRUDENCE EXAMINATION INFORMATION:**

- ▶ ALL APPLICANTS WILL BE REQUIRED TO TAKE A MONTANA **JURISPRUDENCE EXAM AND PASS WITH A SCORE OF 75%. THE EXAM CAN BE TAKEN AFTER APPROVAL OF THE APPLICATION AND BEFORE RECEIVING A DENTAL HYGIENE LICENSE.** *Applicants will be notified by e-mail when the application is approved and a jurisprudence exam will be sent with the notification, This is an open book exam and applicants are strongly encouraged to use the laws and rules for study and reference.*
- ▶ The examination covers the statutes and rules for the practice of dentistry, dental hygiene and denturity.
- ▶ The laws and rules are on our web site at [www.dentistry.mt.gov](http://www.dentistry.mt.gov). **PLEASE DOWNLOAD ALL** the laws and rules on the Board of Dentistry's site.

#### **PROCESSING PROCEDURES**

- The applicant will be notified in writing of any deficient or missing items in the application file. This delay may affect the processing time.
- Once a routine application is complete and approved, which takes approximately 14 days, the applicant will be sent the jurisprudence examination.
- When the examination has been corrected and passage is confirmed, a license may be issued to the applicant. Time for processing the final license depends on the applicant turnaround time on receipt of required documentation and the jurisprudence take home examination.
- Please be sure the two individual references you listed on your application complete the reference questionnaire form and return the form directly to the Board office as soon as possible in order to complete your application.
- All non-routine applications may take up to 120 days for processing.
- The Montana Board does not have temporary licensure for dental hygienists.

**For information with regard to the processing of this application or other concerns please contact the Board of Dentistry application unit at 406-444-5711 or email us at [unitb@mt.gov](mailto:unitb@mt.gov)**

PLEASE BE SURE TO DOWNLOAD THE MONTANA LAWS AND RULES FOR THE PRACTICE OF DENTISTRY FOR THE JURISPRUDENCE EXAMINATION  
WEBSITE ADDRESS: [www.dentistry.mt.gov](http://www.dentistry.mt.gov)

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**Application for Licensure as a dental hygienist:**

**Exam**

**Credentialing**

**Volunteer**

**Restricted Non Resident Volunteer**

**Allow 14 days for processing from the date the Board has a complete routine application.**

1. FULL NAME \_\_\_\_\_  
Last First Middle

2. OTHER NAME(S) KNOWN BY \_\_\_\_\_

3. BUSINESS NAME \_\_\_\_\_

4. BUSINESS ADDRESS \_\_\_\_\_  
Street or PO Box # City and State Zip

5. HOME ADDRESS \_\_\_\_\_  
Street or PO Box # City and State Zip

**PREFERRED MAILING ADDRESS**

BUSINESS  HOME EMAIL ADDRESS \_\_\_\_\_

6. BUSINESS PHONE \_\_\_\_\_ HOME PHONE \_\_\_\_\_ FAX \_\_\_\_\_

7. SOCIAL SECURITY NUMBER \_\_\_\_\_ FOREIGN ID NUMBER \_\_\_\_\_

8. DATE OF BIRTH \_\_\_\_\_ PLACE OF BIRTH \_\_\_\_\_  MALE  FEMALE

9. LICENSE NAME \_\_\_\_\_  
(State your name as it should appear on the license if granted.)

10. Which exam did you take for initial licensure?

<b>WREB</b>	<input type="radio"/> Yes <input type="radio"/> No	Year Taken:	
<b>OTHER</b>	<input type="radio"/> Yes <input type="radio"/> No	Year Taken:	
<b>OTHER</b>	<input type="radio"/> Yes <input type="radio"/> No	Year Taken:	

If "Other" please specify exam: \_\_\_\_\_

11. List all professional licenses you hold or **ever** have held. Verification must be sent directly to Montana from each state/province/territory.

State	License #	Issue Date	Expiration Date	License Method			Requested State Verification	
				<input type="radio"/> EXAM	<input type="radio"/> ENDORSE	<input type="radio"/> OTHER	<input type="radio"/> YES	<input type="radio"/> NO
				<input type="radio"/> EXAM	<input type="radio"/> ENDORSE	<input type="radio"/> OTHER	<input type="radio"/> YES	<input type="radio"/> NO
				<input type="radio"/> EXAM	<input type="radio"/> ENDORSE	<input type="radio"/> OTHER	<input type="radio"/> YES	<input type="radio"/> NO
				<input type="radio"/> EXAM	<input type="radio"/> ENDORSE	<input type="radio"/> OTHER	<input type="radio"/> YES	<input type="radio"/> NO

12. Have you ever had an application for a professional or occupational license refused or denied? If yes, please attach a detailed explanation and provide supporting documentation from the source. Yes No
13. Have you ever withdrawn an application for licensure prior to the licensing agency's decision regarding your application? If yes, please attach a detailed explanation and provide supporting documentation from the source. Yes No
14. Have you ever been denied the privilege of taking an examination required for any professional or occupational license? If yes, please attach a detailed explanation and provide supporting documentation from the source. Yes No
15. Have you ever withdrawn or been suspended, placed on probation, expelled or requested to resign from any postsecondary educational program? If yes, please attach a detailed explanation and provide supporting documentation from the source. Yes No
16. Have you ever requested temporary or permanent leave of absence, been placed on probation, restricted, suspended, revoked, allowed to resign, or otherwise acted against by any professional or occupational education program (i.e., residency, internship, apprenticeship, etc)? If yes, please attach a detailed explanation and provide supporting documentation from the source. Yes No
17. Has a licensing agency initiated or completed disciplinary action against any professional or occupational license you have held? If yes, please provide agency documents including the complaint, initiating documents, orders, final orders, stipulations and consent and/or settlement agreements directly from the source. Yes No
18. Have you ever voluntarily surrendered, cancelled, forfeited, failed to renew a professional or occupational license in anticipation of or during an investigation or disciplinary proceeding or action? If yes, please attach a detailed explanation and provide supporting documentation from the source. Yes No
19. Is there a pending complaint against you with a professional or occupational licensing agency? If yes, please attach a detailed explanation and provide supporting documentation from the source. Yes No
20. Have you ever been the subject of any sanction or action, denial, suspension, revocation, restriction or termination regarding hospital, facility or staff privileges; health maintenance organization participation, third party provider or Medicare/Medicaid participation; or any other privileges? If yes, please attach a detailed explanation and provide supporting documentation from the source. Yes No



- |     |  |     |    |
|-----|--|-----|----|
| 21. | Have you ever been censured, expelled, denied membership or asked to resign from a professional organization related to your profession or occupation? If yes, please attach a detailed explanation and provide documentation from the source.   | Yes | No |
| 22. | Have you ever been the subject of any sanction or action, denial, suspension, revocation, restriction or termination regarding your ability to prescribe, dispense or administer drugs including controlled substances? If yes, please attach a detailed explanation and provide documentation from the source.  | Yes | No |
| 23. | Do you have any initiated or completed action against you by any state, federal, tribal, or foreign licensing jurisdiction? (For example: Drug Enforcement Agency; Alcohol, Tobacco and Firearms; Homeland Security; Indian Health Service, etc.) If yes, please attach a detailed explanation and provide documentation from the source.  | Yes | No |
| 24. | Have any civil legal proceedings been filed against you by a (patient/client), (former patient/client) or employer/employee? If yes, attach a detailed explanation and documentation from the source including initiating document(s) and documentation of final disposition.  | Yes | No |
| 25. | Have you ever been convicted of a misdemeanor or felony crime or do you have a pending criminal charge? "Convicted" for the purposes of this question includes a conviction under appeal, guilty plea, no contest plea, and/or forfeiture of bond. "A pending criminal charge" for the purposes of this question includes a deferred imposition of sentence and/or deferred prosecution. If you answer yes, you must submit a detailed explanation of the events AND the charging documents and final judgments or orders of dismissal. You must report but may omit documentation for: (1) misdemeanor traffic violations older than 10 years and that resulted in fines of less than \$200; and (2) convictions prior to your 18th birthday unless you were tried as an adult. | Yes | No |
| 26. | Have you ever been diagnosed with chemical dependency or another addiction, or have you participated in a chemical dependency or other addiction treatment program? If yes, please attach a detailed explanation and provide documentation regarding evaluations, diagnosis, treatment recommendations and monitoring from the source.   | Yes | No |
| 27. | Have you ever been diagnosed within the past 5 years with a physical condition or mental health disorder involving potential health risk to the public? If yes, please provide a detailed explanation.   | Yes | No |
| 28. | Have you ever been court-martialed or discharged other than honorably from any branch of the armed service? If yes, attach a detailed explanation and documentation from the source.   | Yes | No |

**29. PROFESSIONAL EDUCATION**

Name of University or College	City and State/Province/Territory	Dates Attended	Degree Earned

30. **PRACTICE HISTORY:** List **all** practice after dental hygiene school in chronological order, up to and including the present. Specify nature of activity. Use additional paper if necessary.

Name & Location of Practice	Activity/Position	Inclusive Dates	Reason for Leaving

**31. PROFESSIONAL & CHARACTER REFERENCES.**

Please type or print names and addresses of two references, who have known you or associated with you for a minimum of one year.

Name:	
Address:	
Telephone Number:	
Name:	
Address:	
Telephone Number:	

**DECLARATION**

I authorize the release of information concerning my education, training, record, character, license history and competence to practice, by anyone who might possess such information, to the Montana Board of Dentistry.

I hereby declare under penalty of perjury the information included in my application to be true and complete to the best of my knowledge. In signing this application, I am aware that a false statement or evasive answer to any question may lead to denial of my application or subsequent revocation of licensure on ethical grounds. I have read and will abide by the current licensure statutes and rules of the State of Montana governing the profession. I will abide by the current laws and rules that govern my practice.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

**VERIFICATION OF MORAL/PROFESSIONAL CHARACTER**

**APPLICANT:** Complete the upper portion of this form and mail to each of the character references you have listed in your application.

\_\_\_\_\_  
Legal Signature of Applicant

\_\_\_\_\_  
Date

(Please Type or Print)  
Name of Applicant: \_\_\_\_\_

Address: \_\_\_\_\_

This verification sent to: \_\_\_\_\_

**CHARACTER REFERENCE:** Please answer the following questions concerning the applicant's moral and professional character. This document is your authorization to release any and all information and opinions you have, favorable or otherwise, directly to: Montana Board of Dentistry, PO Box 200513, Helena MT 59620. Your response will be kept confidential.

Name of reference: \_\_\_\_\_ Daytime phone: \_\_\_\_\_

Address: \_\_\_\_\_

Title/profession/position: \_\_\_\_\_

How long have you known the applicant? \_\_\_\_\_ In what capacity? \_\_\_\_\_

To your knowledge, does the applicant have any habits or practices that would adversely affect his/her professional activities? If your answer is "yes", please explain:

Do you consider this applicant worthy of approval to practice as a dental hygienist in Montana?

Please comment on the applicant's professional character, morals and ethics (attach additional sheet as needed):

\_\_\_\_\_  
Signature of Reference

\_\_\_\_\_  
Date

The Applicant and the Board thank you for your assistance.

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**REQUEST FOR OFFICIAL VERIFICATION OF LICENSURE**  
(THIS IS NOT AN ENDORSEMENT CERTIFICATION)

**APPLICANT:** Do **NOT** send this form in with your application. This is to be used as necessary to request official license verification from states or licensing entities in which you currently hold, or ever have held a license.

COMPLETE THE FORM AND MAIL IT TO ANY STATE BOARD IN WHICH YOU ARE REQUESTING OFFICIAL LICENSE VERIFICATION BE SENT TO THE MONTANA BOARD. YOU MAY COPY THIS FORM AS MANY TIMES AS NEEDED. BE ADVISED THAT SOME BOARDS REQUIRE A FEE FOR THIS SERVICE. IT IS RECOMMENDED YOU CONTACT THE BOARDS BY PHONE PRIOR TO MAILING IN THIS FORM TO SEE IF YOU NEED TO INCLUDE PAYMENT.

**LICENSEE INFORMATION**

To Whom It May Concern:

I am applying for a license to practice Dental Hygiene in the State of Montana and the Board of Dentistry requires official license verification. This is your authority to release any information in your files, favorable or otherwise, **DIRECTLY** to:

**Montana Board of Dentistry**  
**PO Box 200513**  
**Helena, MT 59620-0513.**

Your prompt response is appreciated.

Name (Please Print) \_\_\_\_\_ Signature \_\_\_\_\_

Address: \_\_\_\_\_

Street or PO Box # \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

My License Number from your State is: \_\_\_\_\_ License Type: \_\_\_\_\_

This form is to be used to request official verification from states where you hold or have ever held a license. Please **DO NOT** return this form to our office.

**FOR VOLUNTEER LICENSE APPLICATIONS**

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone Number: \_\_\_\_\_ License Number: \_\_\_\_\_

Provide the name and address of the location you intend to provide services under this volunteer license to indigent or uninsured patients in underserved or critical needs areas.

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

**VOLUNTEER LICENSE STATEMENT**

I will not accept any fees, payment or other remuneration for any and all services that I provide while a holder of a Volunteer Dental Hygiene License in Montana.

I hereby declare under penalty of perjury that I will abide by the above statement during the time I hold the Volunteer license. In signing this statement, I am aware that a false statement or accepting payment could result in revocation of my license based upon the board statute and rules. I have read and I am familiar with the applicable dental licensure laws and rules of the State of Montana and will abide by them.

\_\_\_\_\_  
Legal Signature of Applicant Date

Subscribed and sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_ at

\_\_\_\_\_  
City/State

SEAL

\_\_\_\_\_  
Signature of Notary Public

\_\_\_\_\_  
Notary Public Printed Name

\_\_\_\_\_  
For the State of

My commission expires \_\_\_\_\_, \_\_\_\_\_

**DENTAL HYGIENE LOCAL ANESTHESIA APPLICATION (Application fee of \$20)**

Name \_\_\_\_\_

Address \_\_\_\_\_

Phone Number \_\_\_\_\_

- |    |   |     |    |
|----|---|-----|----|
| 1) | Are you currently licensed in the State of Montana as a dental hygienist? | Yes | No |
| 2) | Are you in the process of applying for a Montana dental hygiene license?  | Yes | No |

**PERMIT BY EXAMINATION**

**If you have passed the WREB Local Anesthesia examination within the last 5 years YOU MUST SUBMIT:**

1. Verification of successful passage of the WREB local anesthetic examination
2. Copy of applicant's current CPR, ACLS or PALS card
3. Payment of the \$20.00 fee

**PERMIT BY CREDENTIALING**

**If it has been longer than 5 years since you have passed the WREB Local Anesthesia examination YOU MUST SUBMIT:**

1. Verification of successful completion of the WREB Anesthesia examination
2. Copy of applicant's current CPR, ACLS, or PALS card
3. Copies of any local anesthetic agent authorization(s) held in other states; and
4. Written verification that the applicant has practiced administering local anesthetic agents within the last five years. (Please use form at bottom of application.)
5. Payment of the \$20.00 fee.

***I certify that the information submitted and all questions are true and accurate to the best of my knowledge.***

Signature of Applicant \_\_\_\_\_  
(Required)

Date \_\_\_\_\_

(You may copy this portion of the application if you need more than one verification)

**VERIFICATION FOR ADMINISTRATION OF LOCAL ANESTHETIC AGENTS WITHIN THE LAST FIVE YEARS:**

Name of Dentist/Entity: \_\_\_\_\_

Address \_\_\_\_\_

Phone/Fax: \_\_\_\_\_

Period of Time practicing local anesthetic agents: \_\_\_\_\_

Signature of Dentist \_\_\_\_\_

Date \_\_\_\_\_

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**CERTIFICATION OF HOURS**

(Use for DENTAL HYGIENE CREDENTIALING APPLICANTS, INACTIVE TO ACTIVE PRACTICE, OR VOLUNTEER LICENSE) NOT FOR RESTRICTED NONRESIDENT VOLUNTEER LICENSE

Applicant Name \_\_\_\_\_

Today's Date \_\_\_\_\_

Dates Worked: From \_\_\_\_\_ To: \_\_\_\_\_

Full-time or Part-time and Total hours worked: \_\_\_\_\_

Employer Signature \_\_\_\_\_ Date \_\_\_\_\_

If the applicant had more than one employer during this period of time, the applicant should make copies of this form and have each employer verify the work experience on this form.

Employer's Name \_\_\_\_\_

Please Print

Employer's Address \_\_\_\_\_

Employer's Telephone Number \_\_\_\_\_

I hereby declare under penalty of perjury that information submitted on this form is true and complete to the best of my knowledge. In signing this form, I am aware that a false statement or evasive answer may lead to denial of my application or subsequent revocation of licensure on ethical grounds.

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date

**MONTANA BOARD OF DENTISTRY**

PO BOX 200513  
(301 S PARK, 4TH FLOOR - Delivery) Helena, Montana 59620-0513  
(406)444-5711

EMAIL: DLIBSDLicensingUnitB@mt.gov WEBSITE: www.dentistry.mt.gov

**DENTAL HYGIENE LIMITED ACCESS PERMIT APPLICATION (Application Fee of \$50)**

Name \_\_\_\_\_

Address \_\_\_\_\_

Phone Number \_\_\_\_\_

License Number \_\_\_\_\_

Email \_\_\_\_\_

1. You must have an active, unrestricted Montana Dental Hygiene license to apply for a limited access permit.

2. Do you have any restrictions on your Dental Hygiene license?

Yes No If yes, please provide a written explanation of the restriction and any documentation pertaining to the restriction

3. Provide the name of your current liability insurance carrier, policy number and expiration date of the policy.

Carrier: \_\_\_\_\_

Policy Number \_\_\_\_\_ Expiration date \_\_\_\_\_

4. Provide copies of certificates of attendance of 12 continuing education credits for the three-year cycle immediately preceding this application and a current CPR, ACLS, or PALS card.

5. Please document below at least 2400 clinical hours over the last three years, or a career total of 3000 hours, including a minimum of 350 hours in each of the last two years.

Employer	Place of Employment	Clinical Hours per year	Employment Start Date	Employment End date

If you need additional space please attach your information to the application.

- All approved Limited Access Permit holders will be sent a new computer generated license. Your permit endorsement will be listed on your license.
- You will be required to maintain 12 additional hours of continuing education credits (this is in addition to the 36 hours needed for your Dental Hygiene license) for each three-year cycle succeeding initial issuance of a permit. (See page 2 of Application)
- Applications will not be processed without the appropriate fees, required documents and a signed application form.

*Continued on next page*



**DECLARATION**

I hereby declare under penalty of perjury the information included in my application to be true and complete to the best of my knowledge. In signing this application, I am aware that a false statement or evasive answer to any question may lead to denial of my application or subsequent revocation of licensure on ethical grounds. I have read and am familiar with the applicable dentistry licensure laws of the State of Montana and instructions to applicants for licensing. I also attest that I have read and am familiar with the laws and rules for the Board of Dentistry that apply to the use and restrictions of the Limited Access Permit.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date