

**BOARD OF DENTISTRY**  
PO BOX 200513  
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Helena, Montana 59620-0513  
(406) 444-6880

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**DENTAL HYGIENE LIMITED ACCESS PERMIT APPLICATION**

Application Fee: \$50.00

Name: \_\_\_\_\_

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

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

Email: \_\_\_\_\_

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

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 written documentation of the restriction and documentation related to the restriction
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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 3-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 3-year cycle succeeding initial issuance of a permit.  
Applications will not be processed without the appropriate fees, required documents and a signed application form.

## 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