ARKANSAS STATE BOARD OF DENTAL EXAMINERS
101 East Capitol Avenue, Suite 111
Little Rock, Arkansas 72201
Phone: 501-682-2085 Fax: 501-682-3543
Web: asbde.org Email: asbde@arkansas.gov

PLACE APPLICATION PHOTO HERE
(Headshot or passport photo taken within the last 6 months)

Application for Hygiene License by Credentials

Please fill out using Adobe Acrobat (or similar application). Handwritten applications will not be accepted.

For Board Use:
Lic. #: _____
DOL: _____

A. PERSONAL DATA

First Name | Middle Name | Maiden Name | Last Name | Degree

Mailing Address: (Street or PO Box) | City | State | Zip

Social Security Number | Home Phone # | Business Phone #

Email Address | Date of Birth | Sex | Race

I am a citizen of the United States by (check one): ☐ Birth ☐ Naturalization ☐ I am not a U.S. citizen.

Please check one of the following if it applies to you:

☐ Active duty military service member

☐ Returning military veteran applying within one (1) year of your discharge from active duty

☐ The spouse of an active duty military service member or returning military veteran

B. OTHER STATE DENTAL LICENSES

I am (or have been) licensed to practice Dental Hygiene in the following states/jurisdictions:

State	Method of Licensure (i.e examination, credentials)	License Number	Date Licensed	License Expiration Date

OTHER STATE DENTAL LICENSES (CONTINUE IF NEEDED)

State	Method of Licensure (i.e examination, credentials)	License Number	Date Licensed	License Expiration Date

C. EDUCATION

DENTAL HYGIENE EDUCATION:

Degree	Dates Attended	School	Location

GRADUATE WORK/INTERNSHIP:

School	Dates	Degree/Field

D. CLINICAL AND NATIONAL BOARD EXAMINATIONS

Please check which dental clinical examination you successfully passed:

☐ CDCA (Commission on Dental Competency Assessments)
☐ CITA (Council of Interstate Testing Agencies)
☐ CRDTS (Central Regional Dental Testing Service)
☐ SRTA (Southern Regional Testing Agency)
☐ WREB (Western Regional Examining Board)

Date of successful passage of dental clinical examination: _____

Did you successfully complete the National Board Examination? ☐ Yes ☐ No

E. CONTINUING EDUCATION

List your continuing education units (CEUs) taken **within the last two years**. Applicant must have continuing education credits at least equal to those required of current Arkansas licensees.

- **Record only fifty (40) CEUs.**
- **One of the hours must be on the subject of infection control.**
- **Please enclose a copy of your continuing education certificates with your application.**

Date	Course Title	Instructor/Clinician	Credit Hours

CONTINUING EDUCATION CONTINUED

Date	Course Title	Instructor/Clinician	Credit Hours
		TOTAL NUMBER OF CONTINUING EDUCATION HOURS:	

F. RESUME' & BACKGROUND HISTORY

All statements are to be based on your own knowledge unless the statement is expressly qualified to show the source of your information. If more space is needed, answer the question(s) on separate paper. If a question is not applicable, state that. Pay attention to the requested data on each question.

Give reason(s) why you are applying for an Arkansas dental hygiene license.

List work history for the past 12 years. Include employment dates (from/to), employer, type of practice, and reason for change.

Dates	Employer & Employer's Complete Address	Reason for Change

Make a complete statement of the general character of your practice in dental hygiene since first being licensed to practice in any jurisdiction. Include military or temporary work.

Give a detailed statement regarding any service in the armed forces, including branch of service, dates of active service, rank, serial number, locations, last commanding officer, and your last service address. If separated from service, state the nature of separation and if other than honorable, specify type thereof and circumstances surrounding your release. If applicable, give full particulars as to any formal complaints or disciplinary proceedings against you while serving in the armed forces.

List liability insurance carriers – past and present. Give carrier name, location, coverage dates (from/to), and amount of coverage. List the nature of and the amount of malpractice payments made by any carrier.

Have you ever been suspended from practice, reprimanded, censured or otherwise disciplined or disqualified as a hygienist or as a member of any professional organization, or as a holder of any office (public or private)?

☐ Yes ☐ No	***If "yes", state the dates, facts, disposition of the matter, and the name and address of the authority in possession of the applicable record:***

Have any complaints or charges (formal or informal) ever been made or filed or proceedings instituted against you?

☐ Yes ☐ No	***If "yes", state the dates, facts, disposition of the matter, and the name and address of the authority in possession of the applicable record:***

Have you, in an individual capacity, ever been a party to or claimed any interest in any legal proceeding (civil or criminal) including professional liability?

☐ Yes ☐ No	***If "yes", explain:***

Have you ever been charged, arrested, or questioned regarding the violation of any law (except minor traffic violations)?

☐ Yes ☐ No	***If "yes", explain:***

Have you ever been charged with fraud (formally or informally) in any civil or criminal legal proceeding, or in bankruptcy?

☐ Yes ☐ No	***If "yes", explain:***

Have you ever been adjudicated an incompetent or insane person by any court?

☐ Yes ☐ No	***If "yes", explain:***

Have you ever been adjudicated bankrupt, or has a petition in bankruptcy been filed at any time by your or against you, either alone or in any type association with others? Have you ever been brought in as a party to any proceedings in a bankruptcy court? Have you ever been sued or threatened with suit by the receiver, trustee, or other authority of any bankrupt estate for unlawful preference, conspiracy to conceal assets, or any other fraud or offense, whether punishable by criminal law or not?

☐ Yes ☐ No	***If "yes", explain:***

Have you ever been a voluntary patient in any sanitarium, hospital, or mental institution for the treatment of a mental illness?

☐ Yes ☐ No	***If "yes", explain:***

Are you now (or have you ever been) addicted to narcotics, drugs and/or alcohol? Have you undergone treatment for the addiction(s)?

☐ Yes ☐ No	***If "yes", explain:***

Are there any unsatisfied judgments against you? If yes, list details, giving amounts, dates, and the nature of the judgments and the reason for nonpayment.

☐ Yes ☐ No	***If "yes", give details, amounts, dates, and the nature of the judgments and the reason for nonpayment.***

In addition to the foregoing:

I hereby give my permission for the Arkansas State Board of Dental Examiners to secure information concerning me or any of the statements in this application from any person or any source the Board may desire.

I further agree to submit to questions concerning my qualifications as an applicant by the Board or any member thereof, and to substantiate my statements if desired by the Board.

I have attached a check or money order in the amount of $350.00 to cover the application fee. I understand that this fee is nonrefundable.

I agree to read the Arkansas Dental Practice Act, Dental Corporation Act, and the Rules & Regulations of the Board pertaining to Dentistry and Dental Hygiene and to abide by these Statutes and Rules, and to take and pass (75%) the Arkansas Jurisprudence Examination.

I intend to practice in the State of Arkansas within one year of receiving my Arkansas dental license.

I further state that all facts, statements, and answers contained in this application and other documents are true and correct; I am not omitting any information which might be of value to this Board in determining my qualifications, whether it is called for or not; and I agree that any falsification, omission or withholding of pertinent information or facts concerning my qualifications as an applicant shall be sufficient to bar me from licensure by the Arkansas State Board of Dental Examiners and such falsification, omission, or withholding shall serve as grounds for the revocation, cancellation, or suspension of my Arkansas Dental license if it is not discovered until after issuance.

_____	_____
Signature of Applicant	***Date of Application***

PHYSICIAN'S STATEMENT OF EXAMINATION OF APPLICANT

Note to applicant: Please have your physician or nurse practitioner complete this form and send it to the Board office with your Application for a Dental Hygiene License by Credentials.

I, _____, a duly licensed and practicing physician in the State
(Name of Physician/Nurse Practitioner)

of _____, have this day examined _____
(Name of Applicant)

the applicant herein, and my medical examination reveals that such applicant is free from all infectious and contagious diseases, and such applicant is in sound and good health. This examination made in *(town)* _____

on *(date)* _____, _____.

_____
Signature of Physician or Nurse Practitioner

In accordance with Section 25-19-105 of the Arkansas Freedom of Information Act (FOIA), this form is not open to the public and will not be shared.