THE STATE of ALASKA
Department of Commerce, Community, and Economic Development
Division of Corporations, Business and Professional Licensing

Board of Dental Examiners
PO Box 110806, Juneau, AK 99811
Phone: (907) 465-2550
Email: *BoardOfDentalExaminers@Alaska.Gov*
Website: *ProfessionalLicense.Alaska.Gov/BoardOfDentalExaminers*

Dental Hygienist Advanced Practice Permit Application Instructions

The board may issue an advanced practice permit to a dental hygienist with an Alaska license in good standing under AS 08.32 and who has a minimum of 4,000 documented hours of clinical experience. The permit is subject to all the requirements of AS 08.32.125 and this section. An advanced practice permit expires on February 28 of odd-numbered years and must be renewed to remain active, same as the dental hygienist license.

A licensed dental hygienist holding an advanced practice permit may provide the following services:

- Promote oral health and provide disease prevention education and oral systemic health education;
- Remove calcareous deposits, accretions, and stains from the surfaces of the teeth beginning at the epithelial attachment by scaling and polishing techniques;
- Apply topical preventive or prophylactic agents, including silver diamine fluoride, fluoride varnishes, and pit and fissure sealants;
- Remove marginal overhangs;
- Perform preliminary charting and triage to formulate a dental hygiene assessment and dental hygiene treatment plan;
- Expose and develop radiographs;
- Use local periodontal therapeutic agents;
- Perform nonsurgical periodontal therapy;
- Screen for oral cancer;
- If certified by the board, administer local anesthetic agents (this is a certificate that must be applied for separate from an advanced practice permit);
- Prescribe:
    - Fluoride that is applied or provided to a patient; and
    - Chlorhexidine or a similar antibacterial rinse; and
- Delegate dental operations and services to a dental assistant as provided in AS 08.36.346.

A licensed dental hygienist holding an advanced practice permit may only provide the services listed above to a patient who is unable to access dental treatment because of age, infirmity, or disability and is:

- A resident in a senior center, including a hospital, long-term care facility, adult foster home, residential care facility, or adult congregate living facility;
- A resident in a health care facility, including a mental health residential program or facility for individuals with developmental or other disabilities;
- Held in a local correctional facility for juveniles or adults;
- Enrolled in a nursery school, day care program, vocational training facility, primary school, secondary school, private school, or public charter school;
- Entitled to benefits under 42 U.S.C. 1786 (Special Supplemental Nutrition Program for Women, Infants, and Children);
- Homebound; or
- A resident of a dental health professional shortage area designated under 42 U.S.C. 254e.

A licensed dental hygienist holding an advanced practice permit may provide the services (listed above) to a patient (described above) without the physical presence, authorization, or supervision of a licensed dentist and without a licensed dentist's examination of the patient.

The dental hygienist must:

- Maintain professional liability insurance;
- Provide the patient (or the patient's parent or legal guardian) with:
    - A written notice that the treatment provided will be limited to the services listed above;
    - A written recommendation that the patient be examined by a licensed dentist for comprehensive oral health care services; and

- Assistance in obtaining a referral to a licensed dentist for further dental planning and treatment, including a written description of methods for obtaining a referral and a list of licensed dentists in the patient's community or other resources for finding a dentist;

- Maintain dental charts and other records when treating the dental hygienist's own patients of record and notify the board of the location where these records are to be secured;
- Maintain a current, valid mailing address on file with the board at all times;
- Refer patients who have been assessed by the dental hygienist to a licensed dentist for treatment or planning that's outside the dental hygienist's advanced practice permit scope of practice; and
- Document in the patient's chart the name of the licensed dentist to whom the patient is referred.

The following must be received by the division before your application for Dental Hygienist Advanced Practice Permit can be reviewed by the board:

1. APPLICATION

A completed application, signed and notarized (#08-4860, pages 1-4).

2. FEES

Fees made payable to "State of Alaska."

Nonrefundable Application Fee:	$100.00
Advanced Practice Permit Fee:	$200.00
Total Fees Due:	$300.00

3. AFFIDAVIT OF CLINICAL EXPERIENCE

An Affidavit of Clinical Experience form (#08-4860b) confirming the applicant has a minimum of 4,000 documented hours of clinical experience during the five years preceding the date of application.

4. CPR CERTIFICATION

A copy of the applicant's current certification in cardiopulmonary resuscitation (CPR) techniques that is based upon training equivalent to that required for completion of CPR course certified by the American Health Association or American Red Cross. Online courses are not acceptable unless there is a hands-on component.

5. PROFESSIONAL LIABILITY INSURANCE POLICY OR DECLARATION

A copy of the applicant's current professional liability insurance policy or a Declaration of Professional Liability Insurance form (#08-4860c) that includes the policy number and expiration date of the policy.

6. PROOF OF CONTINUING EDUCATION

Certificates confirming successful completion of at least four (4) hours of continuing education course work covering one or more of the following subject areas:

- Medical emergencies;
- Pediatric and other special health care needs;
- Pharmacology;
- Oral pathology;
- Public health, or other eleemosynary facility, relating to, or supporting charity;
- Patient management; and/or
- General medicine and physical diagnosis.

General Information

APPLICATION PROCESSING:
The average processing time varies by program. When the application is complete and correct, all supporting documents have been received and all fees have been paid, the license may be issued. Start the process far enough in advance to allow for processing time. Applications are reviewed in order of receipt in our office, and walk-in customers should not expect immediate review.

LICENSE TERM:
Licenses are issued for a two-year period and expire on February 28 of odd-numbered years, regardless of the date of issuance, except licenses issued within 90 days of the expiration date which are issued to the next biennial expiration date. One renewal notice will be sent via email or mail at least 30 days before license expiration to the last known email or mailing address of record. Failure to receive a renewal notice does not relieve a licensee from the responsibility of renewing a license on time.

PROFESSIONAL FITNESS QUESTIONS:
A "yes" response in the application does not mean your application will be denied. If you have responded "yes" to any professional fitness questions, submit an explanation with the charging and closing court documentation showing final disposition of charge(s) (e.g. court records, fitness letters, etc.).

DENIAL OF APPLICATION:
Be aware that the denial of an application for licensure may be reported to any person, professional licensing board, federal, state, or local governmental agency, or other entity making a relevant inquiry or as may be required by law.

ADDRESS OR NAME CHANGE:
In accordance with 12 AAC 02.900, it is the applicant's responsibility to notify the division, in writing, of changes of address or name. Name and address change notification forms are available on the division's website. The address of record with the division will be used to send renewals and all other official notifications. The name appearing on the license must be your current legal name.

CERTIFIED TRUE COPIES:
If any of the required documents will be issued under a former name, indicate on the application and submit marriage license and/or court documents that are notarized as a "certified true copy of the original document". To obtain a certified true copy, you must present the notary with the original document along with the photocopy. You must write, "I certify this is a true copy of the original document" and sign your name. The notary will compare the original document with the copy and then notarize your signature.

SOCIAL SECURITY NUMBERS:
AS 08.01.060 requires a U.S. Social Security Number be on file with the division before a professional license is issued. If you do not have a U.S. Social Security Number, complete the Request for Exemption from Social Security Number Requirement form located at *ProfessionalLicense.Alaska.Gov.*

PUBLIC INFORMATION:
All information on the application will be available as public record, unless required to be kept confidential by state or federal law.

ABANDONED APPLICATIONS:
Under 12 AAC 02.910, an application is considered abandoned when 12 months have elapsed since correspondence was last received from or on behalf of the applicant. An abandoned application is denied without prejudice. At the time of abandonment, the division will send notification to the last known address of the applicant, who has 30 days to submit a written request for a refund of biennial license and other fees paid. The application fee will not be refunded. If no request for refund is received within that timeframe, no refund will be issued, and all fees will be forfeited.

BUSINESS LICENSES:
The status of a professional license will directly impact the status of an associated business license. Renewal applications for business licenses are mailed separately. For more information about business licenses, (907) 465-2550 or *BusinessLicense.Alaska.Gov.*

STALE DOCUMENTS:
Application forms, authorizations and verifications older than 12 months from the date the document was received by the division will be considered stale; the document must be resubmitted as appropriate before the application will be considered by the division or a licensing board. Application documents include the application documents and verifications of licensure from other licensing jurisdictions. (12 AAC 02.915)

PAYMENT OF CHILD SUPPORT:
If the Alaska Child Support Enforcement Division has determined that you are in arrears on child support, you may be issued a nonrenewable temporary license valid for 150 days. Contact Child Support Services at (907) 269-6900 to resolve payment issues.

PRESCRIPTION DRUG MONITORING PROGRAM:

All actively licensed practitioners with a DEA registration number valid to use in any state or practice location must register with the Alaska Prescription Drug Monitoring Program (PDMP) within 30 days of initial licensure and use the PDMP to review a patient's prescription history each time before prescribing, administering, or dispensing a federally scheduled II or III controlled substance. For more information, visit *PDMP.Alaska.Gov.*

STATUTES AND REGULATIONS:

The complete set of statutes and regulations for this program are available by written request or online at the division's website: *ProfessionalLicense.Alaska.Gov*. To receive notification of all proposed regulation changes, send a request with your name, preferred contact method (mail or email), and the program you want to be updated on to the regulation specialist at the following email: *RegulationsAndPublicComment@Alaska.Gov.*

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Dental Hygienist Advanced Practice Permit Application

PART I Payment of Fees

Required Fees:	☐ Application and Permit Fee ($100 is Non-Refundable)	**$300.00**

PART II Personal Information

Full Legal Name:		**Dental Hygienist License Number:**	

Provide all other names used (maiden, nicknames, aliases). If any documentation will be received in a prior name, you must provide a certified true copy of the documentation showing proof of legal name change(s).

☐ Not Applicable
☐ Other Names Used: _____

Mailing Address:	P.O. Box or Street	City	State	Zip

Contact Phone:		**Date of Birth:**	

EMAIL AGREEMENT: By choosing to receive correspondence on any matter affecting my license or other business with the Alaska Division of Corporations, Business and Professional Licensing, I agree to maintain an accurate email address through the MY LICENSE web page. I understand that failure to check my email account or to keep the email address in good standing may result in an inability to receive crucial information, potentially resulting in my inability to obtain or maintain licensure.

Email Address:		**Select One:**	☐ Send my Correspondence Electronically ☐ Send my Correspondence by Mail

Note: If both boxes are selected above, you will receive correspondence electronically.

SOCIAL SECURITY NUMBER: AS 08.01.060 requires you to provide your United States Social Security Number. It is considered confidential information and will not be publicly disclosed; it may be used to verify inter-state licensure.	

PART III Hygiene Practice Facility Information

Name of Hygiene Practice Facility or Business:				
Facility or Business Address:	Street	City	State	Zip

PART IV Certifications

- ☐ I certify I have a minimum of 4,000 documented hours of clinical experience during the five (5) years immediately preceding the date of this application; and I understand I must submit the Affidavit of Clinical Experience form (#08-4860b) as part of my application.
- ☐ I certify I hold a current certification in cardiopulmonary resuscitation (CPR) techniques that is based upon training equivalent to that required for completion of CPR course certified by the American Health Association or American Red Cross; I understand online courses are not acceptable unless there is a hands-on component; and I must provide a copy of my CPR certificate (or equivalent) as part of my application.
- ☐ I certify I hold the requirement professional liability insurance; and I understand I must provide a copy of the policy or the Declaration of Professional Liability Insurance form (#08-4860c) – including the policy number and expiration date of the policy – as part of my application.
- ☐ I certify I have obtained at least four (4) hours of continuing education course work as required under 12 AAC 28.936(e); and I understand I must provide copies of the certificates or equivalent documentation to verify my successful completion of those hours.
- ☐ I hereby certify I have reviewed, understand and will abide by the statutes and regulations applicable to my profession (AS 08.36, AS 08.32 and 12 AAC 28).

PART V Professional Fitness Questions

The following questions must be answered. "Yes" answers may not automatically result in license denial.

For each "yes" response to any question, you must provide an explanation and documentation. Use the letter of explanation form (#08-4752) appended to this application; include full details, dates, locations, type of action, organizations or parties involved, and specific circumstances. A separate letter of explanation form must be provided for each "yes" answer documented below. Documentation includes copies of court orders, charging documents, board, or license actions, etc.

The contents of licensing files are generally considered public records, unless required to be kept confidential by state or federal law.

When in doubt, disclose and explain.

1. Have you ever practiced dental hygiene illegally? ☐ **Yes** ☐ **No**

2. Have you ever had a professional license denied, revoked, suspended, or otherwise restricted, conditioned, or limited or have you surrendered a professional license, been fined, placed on probation, reprimanded, disciplined, or entered into a settlement with a licensing authority in connection with a professional license you have held in any jurisdiction including Alaska and including that of any military authorities or is any such action pending? ☐ **Yes** ☐ **No**

3. Have you been convicted of a crime or are you currently charged with committing a crime? For purposes of this question, "crime" includes a misdemeanor, felony, or a military offense, including but not limited to, driving under the influence (DUI) or driving while intoxicated (DWI), driving without a license, reckless driving, or driving with a suspended or revoked license. "Convicted" includes having been found guilty by verdict of a judge or jury, having entered a plea of guilty, nolo contendere or no contest, or having been given probation, a suspended imposition of sentence, or a fine. ☐ **Yes** ☐ **No**

4. Have you ever been the subject of a report from the National Practitioner Data Bank or the American Association of Dental Boards Clearinghouse for Board Actions that relates to criminal or fraudulent activity, or dental malpractice? ☐ **Yes** ☐ **No**

PART V Professional Fitness Questions *(continued)*

5. Are you the subject of a decision based upon a complaint, investigation, review procedure, or other disciplinary proceeding within the five years immediately preceding application, or of an unresolved complaint, investigation, review procedure, or other disciplinary proceeding, undertaken by a state, territorial, local, or federal dental licensing jurisdiction or a dental society? ☐ **Yes** ☐ **No**

6. Are you the subject of an unresolved decision or a decision based upon a complaint, investigation, review procedure, or other disciplinary proceeding, undertaken by a state, territorial, local, or federal dental licensing jurisdiction, dental society, or law enforcement agency that relates to criminal or fraudulent activity, dental malpractice, or negligent dental care and that reflects on your ability or competence to practice dentistry or on the safety or well-being of patients? ☐ **Yes** ☐ **No**

7. Are you currently suffering from any condition, mental or physical, that impairs your judgement or that would otherwise adversely affect your ability to practice dental hygiene in a competent, ethical and professional manner? ☐ **Yes** ☐ **No**

8. Do you use drugs or alcohol in any manner that impairs your ability to practice dental hygiene competently and safely? ☐ **Yes** ☐ **No**

"Yes" Answers

If you answered "yes" to questions 7 or 8, in addition to your personal statement, you must submit a statement from your health care provider indicating your ability to safely practice. Applications submitted without the appropriate attachments will be considered incomplete and will not be processed.

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Notary Signature Page

Applicant Name:		
Alaska License Number (if known):		☐ *Application in Process*

PART VI Notarized Signature

I acknowledge and understand a licensed dental hygienist in Alaska shall adhere to the ethical standards for dental hygienists established by the Alaska Board of Dental Examiners and failure to adhere to the ethical standards may result in imposition of a sanction that is described in AS 08.32.160.

By signature below, I certify if I am granted an advanced practice permit in the State of Alaska as a dental hygienist, I will adhere to the "Code of Ethics for Dental Hygienists," as set out in the American Dental Hygienists' Association document titled Bylaws – Code of Ethics, dated June 23, 2014, adopted by reference as the ethical standards for dental hygienists and applies to all dental hygienists in the state (12 AAC 28.905(a)) as well as all Alaska dental laws.

I hereby certify I am the person herein named and subscribing to this application. I further certify I have read the complete application, and I know the full content thereof. I declare all of the information contained herein, and evidence or other documents submitted herewith are true and correct.

I understand any falsification or misrepresentation of any item or response in this application, or any attachment hereto, or falsification or misrepresentation of documents to support this application, is sufficient grounds for denying, revoking, or otherwise disciplining a license, registration, certificate, or permit to practice in the state of Alaska.

I further understand it is a Class A misdemeanor under Alaska Statute 11.56.210 to falsify an application and commit the crime of unsworn falsification. A person who makes a false statement on this application may be subject to civil and criminal penalties, including prosecution for perjury (AS 11.56.200 & AS 11.56.230).

Notary Stamp	**Applicant Printed Name:**			
	Applicant Signature:			
	Notary Public for State of:		**Subscribed and Sworn to Before me on this Day:**	
	Notary Signature:		**My Commission Expires:**	

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Affidavit of Clinical Experience

This affidavit must be completed by the licensed dental hygienist who wishes to obtain an advanced practice permit to affirm the dental hygienist has a minimum of 4,000 documented hours of clinical experience during the five years preceding the date of application.

List the hours, dates, and location(s) where you obtained your documents hours of clinical experience during the five years immediately preceding the date of your application. Continue on a separate page if necessary.

Applicant Name:	
☐ By my signature below, I hereby certify I have been in practice at the following locations during the dates listed.	

Name of Practice:		**Phone Number:**	
Address:	Street City State Zip		
Clinical Experience Start Date:		**Clinical Experience End Date:**	
Documented Hours of Clinical Experience:			

Name of Practice:		**Phone Number:**	
Address:	Street City State Zip		
Clinical Experience Start Date:		**Clinical Experience End Date:**	
Documented Hours of Clinical Experience:			

Name of Practice:		**Phone Number:**	
Address:	Street City State Zip		
Clinical Experience Start Date:		**Clinical Experience End Date:**	
Documented Hours of Clinical Experience:			

Total Number of Documented Hours of Clinical Experience in the Five (5) Years Immediately Preceding the Date of Application for an Advanced Practice Permit:	

Notarized Signature

By my signature below, I further certify I have a minimum of 4,000 documented hours of clinical experience during the five years immediately preceding the date of my application as required under AS 08.32.125.

Notary Stamp	**Applicant Printed Name:**			
	Applicant Signature:			
	Notary Public for State of:		**Subscribed and Sworn to Before me on this Day:**	
	Notary Signature:		**My Commission Expires:**	

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Advanced Practice Permit Professional Liability Policy Declaration

A copy of a dental hygienist's professional liability insurance policy required per 12 AAC 28.936(a)(5). You may submit a copy of your policy (that includes your policy number and expiration date) **- OR -** complete this form and submit to the board.

12 AAC 28.936. ADVANCED PRACTICE PERMITS. (a)(5) A copy of the applicant's current professional liability policy or declaration page that includes the policy number and expiration date.

Dental Hygienist Name:			
Insurance Carrier Name:			
Liability Insurance Policy Number:		**Policy Expiration Date:**	
Dental Hygienist Printed Name:		**Dental Hygienist License Number:**	
Dental Hygienist Signature:		**Date Signed:**	

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Letter of Explanation for a Professional Fitness "Yes" Answer

Use this form only to explain and document any professional fitness "yes" answers. A "yes" answer is not necessarily disqualifying but concealing one may be.

Each "yes" answer requires a separate explanation and associated documentation. Submit all relevant documentation with this form, even if you have previously provided it.

- **Explanations** include full details, dates, locations, type of action, organizations or parties involved, and specific circumstances. If the space provided is insufficient, make additional copies as needed.
- **Documentation** includes copies of court orders, charging documents, board or license actions, decisions against your professional certification, satisfaction of consent agreements (fines paid, community service completed, off probation, etc.), and fitness to practice letters (statement from your provider that you are safe to practice if you check "yes" to any of the questions regarding mental or physical health, or drug or alcohol abuse or addiction).
- **Disciplinary actions** may include, but not be limited to, suspension, surrender, revocation, probation, academic probation, reprimand, censure, restricted license, limited license, conditioned license, or letters of counseling, concern, advice, warning, caution, admonishment, or reprimand.

If you have multiple "yes" answers or multiple incidents for any professional fitness question, you must use a separate copy of this form and provide a full explanation and documentation for each incident.

The contents of licensing files are generally considered public records, unless required to be kept confidential by state or federal law.

☐ ⇦ **Write the professional fitness question number you are answering "yes" to in the box.**

Location of Incident:		**Date of Incident:**	
Explanation of Incident: When in doubt, disclose and explain. *Make copies as necessary.*			

Did you attach all applicable documents associated with this incident?

☐ Court Orders ☐ Consent Agreements ☐ Disciplinary Actions ☐ Charging Documents

☐ Court Records ☐ Fitness to Practice ☐ All Other Documentation Related to This Incident

☐ I have additional incidents for this "yes" answer, or "yes" answers to other Professional Fitness questions and have attached a separate copy of this form for each incident.

Full Name:		**Program:**	
Signature:		**Date Signed:**	

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Credit Card Payment Form

All major credit cards are accepted. For security purposes, do not email credit card information. Include this credit card payment form with your application.

Name of Applicant or Licensee:			
Profession Type *(e.g., Acupuncture)*:		**License Number *(if applicable)*:**	
I wish to make payment by credit card for the following *(check all that apply):*			**AMOUNT**
☐ **Application Fee:**			
☐ **License or Renewal Fee:**			
☐ **Other *(fine, exam, etc.)*:**			
1.			
2.			
		TOTAL:	0

Name *(as shown on credit card)*:			
Mailing Address:			
Phone Number:		**Email *(Optional)*:**	
Signature of Credit Card Holder:	X		

CREDIT CARD INFO: Your payment cannot be processed unless all fields are completed.

1. Credit Card Number:		**All 3 fields MUST be completed.**
2. Expiration Date:		**This section will be destroyed after the payment is processed.**
3. Security Code:		