

**MONTANA BOARD OF DENTISTRY  
PO BOX 200513**

(301 S PARK, 4TH FLOOR - Delivery)  
Helena, Montana 59620-0513  
(406) 841-2390 or 2331 FAX (406) 841-2305

EMAIL: [dlibsdden@mt.gov](mailto:dlibsdden@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 continuously 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. 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:
  - ✓ 2,400 clinical hours over the last three years or;
  - ✓ 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

5. **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:
  - ✓ Successful completion of a local anesthetic agent course given by a CODA accredited dental hygiene school
  - ✓ Verification that the applicant has practiced administration of local anesthetic agents within the last five years

**FEES:**

**Examination Application Fees**

Application Fee - \$100.00  
Jurisprudence Exam Fee - \$85.00

**Credentialing Application Fees**

Application Fee - \$100.00  
Credentialing Fee - \$75.00  
Jurisprudence Exam Fee - \$85.00

**Other Application Fees**

Volunteer Application Fee - \$5.00  
Limited Access Permit Application Fee - \$ 50.00  
Local Anesthesia Permit Application Fee - \$20.00

**\*\*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 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 Card sent directly from the Joint Commission on Examination. If a card has not already been requested to be sent to Montana you may obtain one by calling (312) 440-2500.
- Verifications of successful passage of a Board approved clinical examination.
- Copy of State license(s) that was or is held for any professional licensed occupation in this or any other state(s).
- 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 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 Card sent directly from the Joint Commission on Examination. If a card has not already been requested to be sent to Montana you may obtain one by calling (312) 440-2500.
- 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 diploma 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.

**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  
153 Weston Parkway Ste 106  
Cary NC 27513 (919) 678-9792 [www.citaexam.com](http://www.citaexam.com)

CRDTS - CENTRAL REGIONAL DENTAL TESTING SERVICE  
1725 SW Gage Blvd.  
Topeka KS 66604-3333 (785) 273-0380 [www.crdts.org](http://www.crdts.org)

NERB - NORTH EAST REGIONAL BOARD OF DENTAL EXAMINERS, INC  
8484 Georgia Avenue, STE 900  
Silver Spring MD 20910 (301) 563-3300 [www.nerb.org](http://www.nerb.org)

SRTA - SOUTHERN REGIONAL TESTING AGENCY INC  
4698 Honeygrove Road STE 2  
Virginia Beach VA 23455-5934 (757) 318-9082 [www.srta.org](http://www.srta.org)

WREB - WESTERN REGIONAL EXAMINING BOARD  
9201 NORTH 25TH AVE, SUITE 185  
PHOENIX AZ 85021  
(602) 944-3315 [www.wreb.org](http://www.wreb.org)

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.

## **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 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 dentistry.
- ▶ The copy of the laws and rules is on our web site at [www.dentistry.mt.gov](http://www.dentistry.mt.gov). **PLEASE DOWNLOAD ALL** the laws and rules on the 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 effect 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 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 at 406-841-2390 or 2331 or email us at [dlibsdden@mt.gov](mailto:dlibsdden@mt.gov).**

PLEASE BE SURE TO DOWNLOAD THE MONTANA LAWS AND RULES FOR THE PRACTICE OF DENTISTRY FOR THE JURISPRUCENCE 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**

**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 \_\_\_\_\_

MALE

8. DATE OF BIRTH \_\_\_\_\_ PLACE OF BIRTH \_\_\_\_\_  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="checkbox"/> Yes <input type="checkbox"/> No	Year Taken:	
<b>CRTDS</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	Year Taken:	
<b>OTHER</b>	<input type="checkbox"/> Yes <input type="checkbox"/> 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. Has a licensing agency ever taken adverse or disciplinary action against your license? If yes, attach agency documents filed in the action including all complaints, initiating documents, orders, final orders, stipulations and consent and/or settlement agreements.  Yes  No

13. Have you ever voluntarily surrendered, cancelled, forfeited or failed to renew a license as a result of any of the following: having a complaint filed against you; entering into a consent agreement with respect to your license as a result of a complaint; during an investigation or during disciplinary proceedings? If yes, attach a detailed explanation identifying each occasion, the date and the substance of the allegations.  Yes  No

14. Has a complaint ever been made against you alleging unethical behavior, standard of care issues, or unprofessional conduct? If yes, attach a detailed explanation.  Yes  No

15. Have you voluntarily or involuntarily surrendered any hospital privileges, health organization participation, Medicare/Medicaid privileges, during a pending investigation, or in anticipation of an investigation, or had such privileges reprimanded, denied, restricted, suspended, placed on probation, revoked or subjected to other sanction or action? If yes, attach a detailed explanation identifying each occasion, the date and the substance of the allegations.  Yes  No

16. Has any legal or disciplinary action been filed against you, which relates to your propriety of, or your fitness to practice this profession (including malpractice, etc.)? If yes, attach a detailed explanation of each instance including the date of the claim, name and address of party complaining, name and address of forum or court where claim was filed, docket or claim number and the substance of the allegations.  Yes  No

17. Have you ever voluntarily or involuntarily surrendered the privilege to prescribe or dispense any drug, including but not limited to controlled substances, or had such privileges investigated, denied, restricted, suspended, revoked or otherwise modified by any governmental agency, including but not limited to the Drug Enforcement Administration, any state licensing or disciplinary court or other entity? If yes, attach a detailed explanation.  Yes  No

18. Have you ever been expelled from or asked to resign from any professional organization or been censured by a professional organization of which you were a member? If yes, attach a detailed explanation.  Yes  No



**24. 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.

**VERIFICATION OF LICENSURE**

THIS IS NOT AN ENDORSEMENT CERTIFICATION

**PLEASE COMPLETE THIS SECTION OF THE FORM AND MAIL TO EACH STATE BOARD IN WHICH YOU ARE NOW OR HAVE EVER BEEN LICENSED TO PRACTICE AS A DENTAL HYGIENIST. YOU MAY COPY THIS FORM AS MANY TIMES AS NEEDED. SOME BOARDS REQUIRE A FEE FOR THIS SERVICE.**

STATE BOARD:

I am applying for a license to practice Dental Hygiene in the State of Montana and the Board of Dentistry requires this form to be completed by each state wherein I hold or have ever held licensure. This is your authority to release any information in your files, favorable or otherwise, **DIRECTLY to the BOARD OF DENTISTRY, BOX 200513, HELENA, MT 59620-0513.** Your early response is appreciated. **The State Board may submit their verification form in lieu of this form.**

\_\_\_\_\_  
(Signature)

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

\_\_\_\_\_  
Address

\_\_\_\_\_  
My License Number is

**DO NOT DETACH - - THIS SECTION TO BE COMPLETED BY AN OFFICIAL OF THE STATE BOARD AND RETURNED DIRECTLY TO THE MONTANA STATE BOARD OF DENTISTRY.**

State of: \_\_\_\_\_

Full Name of Licensee: \_\_\_\_\_

License No. \_\_\_\_\_ Issue Date: \_\_\_\_\_

Licensed by Examination \_\_\_\_\_ Endorsement (List State) \_\_\_\_\_ Other (Please List) \_\_\_\_\_

License is Current?  Yes  No If NO, explain \_\_\_\_\_ License Status:  Active  Inactive  Other

Has License been suspended, revoked, on probation or otherwise disciplined?  Yes  No  
If YES, explain and attach documentation.

Has licensee ever been requested to appear before your Board?  Yes  No  
If YES, explain.

Derogatory information, if any \_\_\_\_\_

Comments, if any \_\_\_\_\_

BOARD SEAL

Signed: \_\_\_\_\_

Title: \_\_\_\_\_

State Board: \_\_\_\_\_

Date: \_\_\_\_\_

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

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

SEAL

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

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

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

**DENTAL HYGIENE LOCAL ANESTHESIA APPLICATION**

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 appropriate 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. Verification of successful completion of a local anesthetic agent course given by a commission on dental accreditation (CODA) accredited dental or CODA accredited dental hygiene school, one of the following will be accepted:
  - a) A letter from the school with the school seal affixed (original, no photocopies).
  - b) A notarized copy of the certificate of local anesthetic agent course completion.
  - c) A notarized copy of the dental or dental hygiene transcript with the local anesthetic agent course recorded.
- 4. Copies of any local anesthetic agent authorization(s) held in other states; and
- 5. Written verification that the applicant has practiced administering local anesthetic agents within the last five years. (Please use form at bottom of application.)
- 6. Payment of the appropriate 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)

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

DENTAL HYGIENE LIMITED ACCESS PERMIT APPLICATION

Name \_\_\_\_\_

Address \_\_\_\_\_

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

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 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 name and address of the public health facility where you intend to utilize this limited access permit:

Name \_\_\_\_\_

Address \_\_\_\_\_

5. Provide copies of certificates of attendance of 12 additional continuing education credits for the three-year cycle immediately preceding this application.

6. 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.
- 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.

---

Signature of Applicant

---

Date



### VIRTUAL TERMINAL PAYMENT FORM

For this service the Business Standards Division now accepts credit card payments using either MasterCard or Visa or an electronic check (**please do not send cash**). You may fill in the appropriate form below to submit payments. ***This document will be destroyed after the payment is processed.***

**NAME OF APPLICANT:** \_\_\_\_\_

**Name of Accountholder:** \_\_\_\_\_  
(as it appears on credit card or on printed check)

**Address of Accountholder:** \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

**Phone Number of Accountholder:** \_\_\_\_\_

**Please check method of payment:**

VISA       MASTER CARD



**Credit Card Number:**

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

**Expiration Date:**      **Amount Authorized:**

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

**Important:** This transaction will appear on your credit card statement as:  
**Discoveringmontana-SC.**

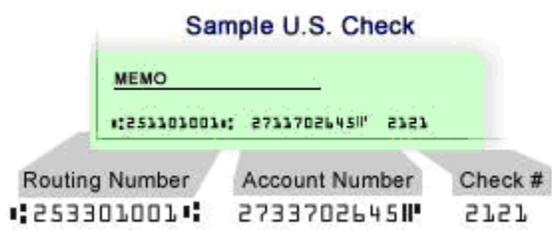
**E-CHECK**      **Amount Authorized:**

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Name of Bank: \_\_\_\_\_

Routing Number: \_\_\_\_\_

Account Number: \_\_\_\_\_



**Important:** This transaction will appear on your bank statement as an electronic transaction with the words: **Montana Interact BSD-VT.**