MARYLAND STATE BOARD OF DENTAL EXAMINERS

Spring Grove Hospital Center • Benjamin Rush Building • 55 Wade Avenue • Catonsville, Maryland 21228 • (410) 402-8510

APPLICATION FOR RECOGNITION TO ADMINISTER LOCAL ANESTHESIA BY INFILTRATION AND INFERIOR ALVEOLAR NERVE BLOCK

Use this form if you seek recognition to administer local anesthesia by Infiltration and inferior alveolar nerve block by virtue of certification or other recognition in another state.

There is another form for those who are not recognized in another state.

GENERAL INSTRUCTIONS

Complete all portions of the application. Enclose a $50 (dollar) non-refundable check or money order made payable to the Maryland State Board of Dental Examiners. Enclose all necessary documents. Failure to do so may result in the return of the application.

Notice For Mailing List:
The information collected on this application form is collected for the purposes of the Board's functions under the Annotated Code of MD, Health Occupations Article, Title 4. Failure to provide the information may result in denial of your application. You have a right to inspect, amend, and request correction of this information. The Board may permit inspection of this information or make it available to others only as permitted by federal and State law. Under the Maryland Public Information Act, Annotated Code of Maryland, General Provisions Article, §4-333, the Board may provide, for a fee, a list of licensees' names and addresses to professional associations and other entities. You may request in writing that your name be omitted from such lists.

SECTION I – GENERAL INFORMATION

Name (Last, First, Middle Initial):	
Address of Record: (Street Address)	
City, State, Zip:	
MD Dental Hygiene License Number:	

Note: If the address you have provided to the Board in this application differs from the address you have on file with the Board you must file a change of address form with the Board. The Board will not change the address it has on file if the address on this form differs from the address it already has on file. Failure to do so may result in your not receiving important information from the Board and may ultimately result in disciplinary action. Please keep an updated address on file with the Board at all times.

A. Social Security Number: ☐☐☐ — ☐☐ — ☐☐☐☐
(There is a statutory requirement that you disclose your social security number. It will be used for identification purposes only.)

B. Date of Birth: ☐☐ — ☐☐ — ☐☐☐☐

C. Home Phone Number: ☐☐☐ — ☐☐☐ — ☐☐☐☐

D. Cell Phone Number: ☐☐☐ — ☐☐☐ — ☐☐☐☐

E. Work Phone Number: ☐☐☐ — ☐☐☐ — ☐☐☐☐

F. E-Mail Address:

G. Gender Identification: ☐ Female ☐ Male

H. Race/Ethnic Identification – Please check <u>all</u> that apply

Are you of Hispanic or Latino origin? Yes ☐ No ☐
(A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.)

Select one or more of the following racial categories:

1. ☐ American Indian or Alaska Native (A person having origins in any of the original peoples of North or South America, including Central America, and who maintains tribal affiliations or community attachment.)
2. ☐ Asian (A person having origin in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.)
3. ☐ Black or African American (A person having origins in any of the black racial groups of Africa.)
4. ☐ Native Hawaiian or other Pacific Islander (A person having origins in the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.)
5. ☐ White (A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.)

I. Licensure in other states:

List other states or jurisdictions in which you hold or have held a dental hygiene license.

State	License Number	Expiration Date

J. Certification in other states:

List other states or jurisdictions in which you hold or have held a certificate to administer local anesthesia.

State	Certificate Number	Expiration Date

SECTION II - EDUCATION

A. School of Dental Hygiene (Name, City, State, Country): _____

_____

B. Date of Graduation: _____ **Degree Earned:** _____

SECTION III – RECOGNITION TO ADMINISTER LOCAL ANESTHESIA BY INFILTRATION AND INFERIOR ALVEOLAR NERVE BLOCK

A. What current state certification in local anesthesia are you using as a basis for certification in Maryland.

Name of state: _____

Date certification was issued: _____

Date of expiration: _____

B. Have you passed the American Board of Dental Examiners Inc. Local Anesthesia Examination for Dental Hygienists?

☐ Yes ☐ No

C. If you answered "Yes" to question B. provide the date on which you passed:

_____

D. Have you successfully administered local anesthesia at least 25 times in the 2 year period immediately preceding the date of this application.

☐ Yes ☐ No

If you answered "Yes" to question D. attach a notarized affidavit to this application. You must sign and date the affidavit which must contain the following language: "I solemnly affirm under the penalties of perjury that the contents of the foregoing affidavit are true to the best of my knowledge, information, and belief." (A form Affidavit is attached).

SECTION IV - CHARACTER AND FITNESS

If you answer "YES" to any question(s) in Section V– Character and Fitness, attach a separate page with a complete explanation of each occasion. Each attachment must have your name in print, signature, and date.

YES	NO	
☐	☐	a. Has any licensing or disciplinary board of any jurisdiction, including Maryland, or any federal entity denied your application for licensure, reinstatement, or renewal, or taken any action against your license, including but not limited to reprimand, suspension, revocation, a fine, or non-judicial punishment? If you are under a Board Order or were ever under a Board Order in a state other than Maryland you must enclose a certified legible copy of the entire Order with this application.
☐	☐	b. Have any investigations or charges been brought against you or are any currently pending in any jurisdiction, including Maryland, by any licensing or disciplinary board or any federal or state entity?
☐	☐	c. Has your application for a dental hygiene license in any jurisdiction been withdrawn for any reason?

Character and Fitness Questions – Contd.

YES	NO	
☐	☐	d. Has an investigation or charge been brought against you by a hospital, related institution, or alternative health care system?
☐	☐	e. Have you had any denial of application for privileges, failure to renew your privileges, or limitation, restriction, suspension, revocation or loss in privileges in a hospital, related health care facility, or alternative health care system?
☐	☐	f. Have you pled guilty, nolo contendere, had a conviction or receipt of probation before judgment or other diversionary disposition of any criminal act, excluding minor traffic violations?
☐	☐	g. Have you pled guilty, nolo contendere, had a conviction, or receipt of probation before judgment or other diversionary disposition for an alcohol or controlled dangerous substance offense, including but not limited to driving while under the influence of alcohol or controlled dangerous substances?
☐	☐	h. Do you have criminal charges pending against you in any court of law, excluding minor traffic violations?
☐	☐	i. Do you have a physical condition that impairs your ability to practice dental hygiene?
☐	☐	j. Do you have a mental health condition that impairs your ability to practice dental hygiene?
☐	☐	k. Have the use of drugs and/or alcohol resulted in an impairment of your ability to practice dental hygiene?
☐	☐	l. Have you illegally used drugs?
☐	☐	m. Have you surrendered or allowed your license to lapse while under investigation by any licensing or disciplinary board of any jurisdiction, including Maryland, or any federal or state entity?
☐	☐	n. Have you been named as a defendant in a filing or settlement of a malpractice action?
☐	☐	o. Has your employment been affected or have you voluntarily resigned from any employment, in any setting, or have you been terminated or suspended, from any hospital, related health care or other institution, or any federal entity for any disciplinary reasons or while under investigation for disciplinary reasons?

The Well Being Committee assists dental hygienists and their families who are experiencing personal problems. The Committee has helped numerous dental hygienists over the years with problems such as stress, drug dependence, alcoholism, depression, medical problems, infectious diseases, neurological disorders and other illnesses that cause impairment. For more information please call 800-974-0068.

Release and Certification:

I hereby affirm that I have read and followed the above instructions. I hereby certify that all information in this application is accurate and correct.

I agree that the Maryland State Board of Dental Examiners (the Board) may request any information necessary to process my application for recognition to administer local anesthesia by infiltration and inferior alveolar nerve block in Maryland from any person or agency, including but not limited to undergraduate and postgraduate program directors, individual dentists, government agencies, the National Practitioner Data Bank, the Healthcare Integrity and Protection Data Bank, hospitals, and other licensing bodies, and I agree that any person or agency may release to the Board the information requested. I also agree to sign any subsequent release for information that may be requested by the Board.

I agree that I will fully cooperate with any request for information or with any investigation related to my practice of dental hygiene as a licensed dental hygienist in the State of Maryland.

During the period in which my application is being processed, I shall inform the Board within 30 days of any change to any answer I originally gave in this application, any arrest or conviction, any change of address or any action that occurs based on accusations that would be grounds for disciplinary action under the Annotated Code of Maryland, Health Occupations §4-315.

_____ _____

Applicant Signature **Date**

NOTARY SECTION

State of _____, County of _____, Then personally appeared the above named _____, and signed and sworn to the truth of the foregoing statements in my presence.

Notary Public: _____

My Commission Expires: _____

SEAL

Check List for Dental Hygienist Recognition to Administer Local Anesthesia by Infiltration and Inferior Alveolar Nerve Block by Virtue of Recognition in Another State

The Board <u>may not</u> process an application until each provision or requirement is met and each document is received. Please ensure that your application is complete before it is submitted.

☐ 1. NOTARIZED APPLICATION: Completed application form accompanied by supporting documents. The licensure process could take up to a minimum of **<u>30 days</u>** after submission of a competed application. Plan your application time accordingly.

☐ 2. The $50 non-refundable application fee payable by check or money order made out to the Maryland State Board of Dental Examiners (MSBDE).

☐ 3. Certified copy of your most recent certification to administer local anesthesia from the state Identified in your answer to question Section III A.

☐ 4. Grades from CDCA indicating that you passed the Local Anesthesia by Infiltration and Inferior Nerve Block.

☐ 5. Notarized affidavit indicating that you have successfully administered local anesthesia at least 25 times in the past 2-year period immediately preceding the date of this application. (Affidavit form attached)

☐ 6. Copy of court documents for any discrepancies of the applicant's name if documents submitted bear different name(s), [i.e. marriage certificate, divorce decree, legal name change].

MAIL APPLICATION AND SUPPORTING DOCUMENTS TO:

Maryland State Board of Dental Examiners
Spring Grove Hospital Center
Benjamin Rush Building
55 Wade Avenue
Catonsville, MD 21228
ATTN: Local Anesthesia Recognition

Affidavit

Board Recognition to Administer Local Anesthesia by Infiltration and Inferior Alveolar Nerve Block by Virtue of Recognition in Another State

Complete This Affidavit Only If You Seek Recognition to Administer Local Anesthesia by Infiltration and Inferior Alveolar Nerve Block by Virtue of Recognition in Another State

I, _____, a registered dental hygienist in the State of Maryland do solemnly affirm under the penalties of perjury that I have successfully administered local anesthesia at least 25 times in the 2-year period immediately preceding the date of this application.

_____ _____

Date Signature

NOTARY

STATE OF _____ CITY/COUNTY OF _____

I HEREBY CERTIFY THAT on this _____ day of _____, 20____, before me, a Notary Public of the State of Maryland and the City/County aforesaid, personally appeared before me _____ and made oath in due form of law that signing the foregoing Affidavit was his/her voluntary act and deed.

AS WITNESS my hand and Notarial Seal.

_____

Notary Public

My Commission Expires: _____