



ARKANSAS STATE BOARD OF DENTAL EXAMINERS

101 East Capitol Avenue, Suite 111
Little Rock, Arkansas 72201 Phone: 501-682-2085
Web: healthy.arkansas.gov Email: asbde@arkansas.gov

PLACE APPLICATION PHOTO HERE

(Headshot or passport photo taken within the last 6 months)

Application for License to Practice Dental Hygiene

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): <input type="checkbox"/> Birth <input type="checkbox"/> Naturalization <input type="checkbox"/> I am not a U.S. citizen.				
Please check one of the following if it applies to you:				
<input type="checkbox"/> Active duty military service member				
<input type="checkbox"/> Returning military veteran applying within one (1) year of your discharge from active duty				
<input type="checkbox"/> The spouse of an active duty military service member or returning military veteran				

B. OTHER STATE DENTAL HYGIENE LICENSES

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

State/Jurisdiction	How licensed	License Number	Date Licensed	Years of Practice

C. EDUCATION

DENTAL HYGIENE EDUCATION:			
Degree	Dates Attended	School	Date of Graduation

D. CLINICAL AND NATIONAL BOARD EXAMINATIONS

Please check which dental hygiene 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: _____

Have you successfully completed the National Board Examination? Yes No

E. BACKGROUND HISTORY

If you answer "yes" to any of the following questions, please attach a detailed explanation.

Have you even been charged with, or convicted of a felony? Yes No

Have you ever been charged with, or convicted of, been a party to, or been disciplined for violation of the dental laws of this or any other jurisdiction or professional association? Yes No

Are you, or have you ever been, addicted to the use of alcohol, controlled substances or other dangerous drugs?
 Yes No

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 \$5.00 to cover the application fee. I understand that this fee is nonrefundable.

I agree to read the Dental Practice Act of Arkansas and the Rules & Regulations of the Board pertaining to Dentistry and Dental Hygiene; and I further state that all facts, statements, and answers contained in this application 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 sufficient 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.

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.***