



# APPLICATION FOR A DENTAL HYGIENE LOCAL ANESTHETIC PERMIT

STATE BOARD OF DENTISTRY  
PROFESSIONAL LICENSING AGENCY  
402 West Washington Street, Room W072  
Indianapolis, Indiana 46204  
Telephone: (317) 234-2054  
Email: [pla8@pla.in.gov](mailto:pla8@pla.in.gov)  
[www.pla.IN.gov](http://www.pla.IN.gov)

\*Your Social Security number is requested by the agency in accordance with IC 4-1-8-1. Disclosure is mandatory and this record cannot be processed without it.

FOR OFFICE USE ONLY	
APPLICATION FEE	
DATE FEE PAID <i>(month, day, year)</i>	
RECEIPT NUMBER	
APPLICANT NUMBER	
ERMIT NUMBER	
PERMIT ISSUE DATE <i>(month, day, year)</i>	

DO NOT WRITE ABOVE THIS LINE.

APPLICANT INFORMATION		
Name of applicant <i>(last, first, middle, maiden)</i>		*Social Security number
Address <i>(number and street or rural route number)</i>		
City	State	Zip Code
Date of Birth <i>(month, day, year)</i>		Place of Birth <i>(city, state or country)</i>
Telephone Number <i>(daytime)</i>		Email Address
Indiana Dental Hygiene License Number		Expiration Date

DENTAL HYGIENE DEGREE GRANTED BY:		
Name of School	Location of School	Date of Graduation <i>(month, day, year)</i>

DENTAL HYGIENE ANESTHETIC COURSE COMPLETED:	
Name of School	Location:
Type of Training Received: <input type="checkbox"/> Undergraduate <input type="checkbox"/> Post-graduate	Date of Completion <i>(month, day, year)</i>

EXAMINATION			
Check appropriate boxes indicating which local anesthesia examination you have taken:			
EXAMINATIONS TAKEN	List the number of times taken	Date of most recent examination. <i>(month, year)</i>	Where taken? <i>(state or country)</i>
<input type="checkbox"/> North East Regional Board (NERB)			
<input type="checkbox"/> Western Regional Examining Board (WREB)			
<input type="checkbox"/> State Board Examination Which State? _____			
<input type="checkbox"/> Other Examination. _____			

**STATE(S) OF LICENSURE**

Please list all states in which you have been licensed to practice any regulated Health Occupation and Registered to Administer Local Dental Anesthesia.

STATE	TYPE OF LICENSE, CERTIFICATE, OR REGISTRATION	NUMBER	DATE ISSUED (month, year)	DATE EXPIIRED (month, year)	CURRENT STATUS

**EMPLOYMENT HISTORY**

List all places of employment since graduation from Dental Hygiene School. If additional space is needed, please make additional copies of this page and attach to application.

**Employer #1**

Name of Employer		Name of Facility			
Employer Address (number and street or rural route number)					
City		State		Zip Code	
Hours Worked Per Week		Dates Worked		From (month, day, year) To (month day, year)	
Employment Responsibilities: (List all responsibilities regarding this employment)					

**Employer #2**

Name of Employer		Name of Facility			
Address (number and street or rural route number)					
City		State		Zip Code	
Hours Worked Per Week		Dates Worked		From (month, day, year) To (month day, year)	
Employment Responsibilities: (List all responsibilities regarding this employment)					

**Employer #3**

Name of Employer		Name of Facility			
Address (number and street or rural route number)					
City		State		Zip Code	
Hours Worked Per Week		Dates Worked		From (month, day, year) To (month day, year)	
Employment Responsibilities: (List all responsibilities regarding this employment)					

## QUESTIONS

If you answer "yes" to any of the nine (9) questions on the application, the applicant must explain fully in a **signed and notarized affidavit**, meaning an explanation or statement of facts and or events, including all related details. Describe the event including location, date and disposition. If you have a malpractice action, provide names(s) of plaintiff(s). Letters from attorneys or insurance companies are not accepted in lieu of your statement; however they may accompany your affidavit.

1. Has disciplinary action ever been taken regarding any health license, certificate, registration or permit you hold or have held?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Have you ever been denied a license, certificate, registration or permit to practice dental hygiene or any regulated health occupation in any state (including Indiana) or country, or surrendered your license?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Do you have any condition or impairment (including a history of alcohol or substance abuse) that currently interferes, or if left untreated may interfere, with your ability to practice in a competent and professional manner?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Have you ever been the subject of an investigation by a regulatory agency concerning your license?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. <i>Except for minor violations of traffic laws resulting in fines, and arrests or conviction that have been expunged by a court,</i> (1) have you ever been arrested; (2) have you ever entered into a prosecutorial diversion or deferment agreement regarding any offense, misdemeanor, or felony in any state; (3) have you ever been convicted of any offense, misdemeanor, or felony in any state; (4) have you ever pled guilty to any offense, misdemeanor, or felony in any state; or (5) have you ever pled nolo contendere to any offense, misdemeanor, or felony in any state?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Have you ever been denied staff membership or privileges in any hospital or health care facility or had such membership or privileges revoked, suspended or subjected to any restrictions, probation or other type of discipline or limitations?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Have you ever been admonished, censured, reprimanded or requested to withdraw, resign or retire from any hospital or health care facility in which you have trained, held staff membership or privileges or acted as a consultant?	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Have you ever had a malpractice judgment against you or settled any malpractice action?	<input type="checkbox"/> Yes <input type="checkbox"/> No
9. Have you ever been terminated or disciplined by your employer while practicing as a dental hygienist or resigned in lieu of discipline?	<input type="checkbox"/> Yes <input type="checkbox"/> No

## APPLICATION AFFIRMATION

I hereby swear or affirm, under the penalties of perjury, that the statements made in this application are true, complete and correct.

<b>Signature of applicant</b>	<b>Date signed (month, day, year)</b>
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## AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorized, request and direct any person, firm officer, corporation, association, organization or institution to release to the Professional licensing Agency any files, documents, records or other information pertaining to the undersigned requested by the Agency, or any of its authorized representatives in connection with processing my application for a dental hygiene anesthesia permit.

I hereby release the aforementioned persons, firms, officers, corporations, associations, organizations and institutions from any liability with regard to such inspection or furnishing of any such information.

I further authorize the Professional Licensing Agency to disclose to the aforementioned organizations, persons, and institutions from any information which is material to my application, and I hereby specifically release the Agency and Board from any and all liability in connection with such disclosure.

A photo static copy of this authorization has the same force and effect as the original.

## AFFIRMATION

I hereby swear or affirm that I have read the above statements and agree to same.

<b>Signature of applicant</b>	<b>Date signed (month, day, year)</b>
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