



STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

FOR OFFICE USE ONLY
LICENSE NO.:
DATE ISSUED:
EXAM: ENDO: REIN:

APPLICATION FOR LICENSE TO PRACTICE DENTAL HYGIENE

Check one: Exam Endorsement Reinstatement CT License #

First Name: MI: Last Name: Maiden Name:

Social Security No.: E-mail:

Name and Mailing Address: This will be how your name and address will appear on your official license, your address of record for all mailings from this office and releasable pursuant to Freedom of Information requests.

Name on License:

Address:

City, State, Zip:

Phone Number: Date of Birth: Gender:

RACE/ETHNIC DATA: (This section is voluntary. Information gathered will be used solely for the purpose of examining the demographics of Connecticut licensees. This data will not be used for discriminatory purposes and will not be considered in the evaluation of your application.)

AMERICAN INDIAN OR ALASKAN NATIVE: Persons having origins in any of the original peoples of North America, and who maintain cultural identification through tribal affiliation or community recognition.

ASIAN OR PACIFIC ISLANDER: Persons having origins in any of the original peoples of the Far East, Southeast Asia the Indian Subcontinent of the Pacific Islands. This area includes, for example, China, Japan, Korea, the Philippine Islands, and Samoa.

BLACK: Persons having origins in any of the black racial groups of Africa.

HISPANIC: Persons of Mexican, Puerto Rican, Central or South American or other Spanish culture or origin, regardless of race.

WHITE (not of Hispanic Origin): Persons having origins in any of the original peoples of Europe, North Africa, or the Middle East.

PROFESSIONAL EDUCATION:

Institution:

Address: NO. & STREET CITY STATE ZIP CODE

Dates attended from: To:

Degree/diploma received: Date received:

Have you taken or do you plan to take the National Board Examination? Yes No. If yes, indicate the date of the examination:

Have you taken, or do you plan to take, the Northeast Regional Examination (NERB)? Yes No. If yes, indicate the date of the examination.

OUT OF STATE LICENSES:

List all states/territories of the United States in which you are now or have ever been licensed:

STATE	LICENSE NO.	EXPIRATION DATE	LICENSED BY:	
			EXAM	ENDORSEMENT

PROFESSIONAL HISTORY: Answer 1-7 by checking YES or NO. If you answer YES, follow directions below.

1. Have you ever been censured, disciplined, dismissed or expelled from, had admissions monitored or restricted, had privileges limited, suspended or terminated, been put on probation, or been requested to resign or withdraw from any of the following: Yes No

- Any hospital, nursing home, clinic, or similar institution;
- Any health maintenance organization, professional partnership, corporation, or similar health practice organization, either private or public;
- Any professional school, clinical clerkship, internship, externship, preceptorship or postgraduate training program;
- Any third party reimbursement program, whether governmental or private?

2. Have you ever had your membership in or certification by any professional society or association suspended or revoked for reasons related to professional practice? Yes No

3. Has any professional licensing or disciplinary body in any state, the District of Columbia, a United States possession or territory, or a foreign jurisdiction, limited, restricted, suspended or revoked any professional license, certificate, or registration granted to you, or imposed a fine or reprimand, or taken any other disciplinary action against you? Yes No

4. Have you ever, in anticipation or during the pendency of an investigation or other disciplinary proceeding, voluntarily surrendered any professional license, certificate or registration issued to you by any state, the District of Columbia, a United States possession or territory, or a foreign jurisdiction? Yes No

5. Have you ever been subject to, or do you currently have pending, any complaint, investigation, charge, or disciplinary action by any professional licensing or disciplinary body in any state, the District of Columbia, a United States possession or territory, or a foreign jurisdiction or any disciplinary board/committee of any branch of the armed services? You need not report any complaints dismissed as without merit. Yes No

If your answer is "yes" to any of the above questions (1-5), please give full details, names, addresses, etc. on a separate NOTARIZED statement.

6. Have you ever entered into, or do you currently have pending, a consent agreement of any kind, whether oral or written, with any professional licensing or disciplinary body in any state, the District of Columbia, a United States possession or territory, any branch of the armed services or a foreign jurisdiction? Yes No

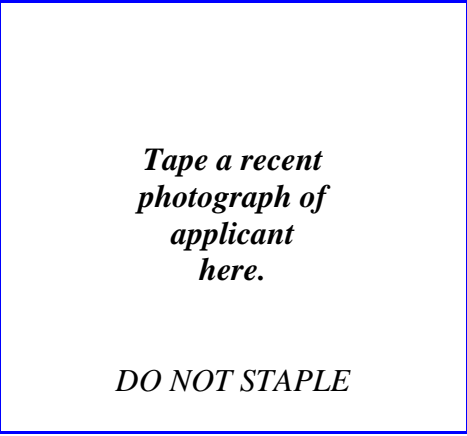
If "yes", give full details, names, addresses, etc. on a separate, NOTARIZED statement. Also submit a NOTARIZED copy of the agreement.

7. Have you ever been found guilty or convicted as a result of an act which constitutes a felony under the laws of this state, federal law or the laws of another jurisdiction and which, if committed within this state, would have constituted a felony under the laws of this state? Yes No

If "yes", give full details, dates, etc. on a separate NOTARIZED statement and furnish a Certified Court Copy (with court seal affixed) of the original complaint, the answer, the judgment, the settlement, and/or the disposition.

PHOTOGRAPH:

NOTARIZATION:



On this _____ day of _____ 20 _____,

_____ (**applicant's name**)
 personally appeared before me, who being duly sworn says that she/he is the
 person referred to in the foregoing application and that the photograph attached
 hereto is a true picture of self and that the statements made herein are true in
 every respect.

SIGNATURE OF APPLICANT

Sworn to before me this _____ day of _____ 20 _____.

My commission expires _____.

SIGNATURE OF NOTARY PUBLIC

**Please return this application and fee for \$150.00 (certified bank check or money order) made payable to,
 "Treasurer, State of CT" to:**

Department of Public Health
 Dental Hygiene Licensure-Remittance Unit
 410 Capitol Avenue MS# **12MQA**
 P.O. Box 340308
 Hartford, CT 06134-0308