NEVADA STATE BOARD OF DENTAL EXAMINERS
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OFFICE USE ONLY	
Date Received:	
Payment Amount:	
Staff Initials:	

BIENNIAL ACTIVE LICENSE RENEWAL July 1, 2026 – June 30, 2028

RENEWAL OF YOUR NEVADA DENTAL RELATED LICENSE IS COMPLETE UPON THE BOARD'S PHYSICAL RECEIPT OF ALL REQUIRED INFORMATION NO LATER THAN THE DATE REQUIRED PER NRS 631.330. INCOMPLETE OR ILLEGIBLE RENEWAL APPLICATIONS WILL NOT BE PROCESSED.

A. LICENSE TYPE

Dentistry Licenses:	☐ General Dentist	☐ Specialty Dentist	☐ Restricted Geographical
Dental Hygiene Licenses:	☐ Registered Dental Hygienist	☐ Restricted Geographical	
Dental Therapist:	☐ Dental Therapist	☐ Restricted Geographical	
Expanded Function Dental Assistant (EFDA):	☐ EFDA	☐ Restricted Geographical	

ACTIVE LICENSURE DATES FOR RENEWAL PERIOD

Active Licensure Dates:	Start: MM/ DD/ YYYY	End: MM/ DD/ YYYY

B. CONTACT INFORMATION

First Name:	Middle Name:	Last Name:	License Number:
Home Phone:	Cell Phone:	Email Address:	

Pursuant to NAC 631.150, all licensees are required to keep the Board informed of their current address(es). Changes to any address must be reported to the Board office in writing within thirty (30) days of such change.

IF YOU WORK AT OR OWN MORE THAN ONE (1) OFFICE, PROVIDE ALL OTHERS ON A SEPARATE SHEET

Office Name/Practice Name/DBA:		Office Address:		
City:	State:	Zip Code:	Office Phone:	Office Fax:
Address Change Effective Date (if changed):		☐ Mailing Address is the same as Office Address		
Home Address:			Apt/Ste:	
City:		State:	Zip Code:	
Address Change Effective Date (if changed):		☐ Mailing Address is the same as Home Address		
Mailing Address (if applicable):			Apt/Ste:	
City:		State:	Zip Code:	
Address Change Effective Date (if changed):				

C. NEVADA BUSINESS LICENSE REPORTING AND AUXILIARIES

All licensees MUST complete this section, regardless of license status. Please select ONE (1) option:

PER NRS 622.240 - IF YOU HAVE MORE THAN ONE (1), LIST ADDITIONAL BUSINESS LICENSES ON A SEPARATE SHEET INCLUDING BUSINESS LICENSE NUMBER, STREET ADDRESS, CITY, STATE, AND ZIP CODE.

☐ I do NOT have a Nevada business license number (if selected, skip to Section D)

☐ I have applied for a Nevada business license with the Nevada Secretary of State upon compliance with the provision of NRS Chapter 76 and my application is pending (if selected, skip to Section D)

☐ I have already obtained a Nevada business license and have a business license number assigned to me by the Nevada Secretary of State upon compliance with the provisions of NRS Chapter 76 (if selected, you must provide the requested business information and answer the Dental Auxiliaries portion below)

Name of Business:

Business License Number:

Street Address:	City:	State:	Zip Code:

The Nevada State Board of Dental Examiners is not the arbiter of determining whether a licensee needs or receives a business license. Information about the Nevada business license and contracts can be found on the Secretary of State's website.

DENTAL AUXILIARIES *(ONLY for DENTISTS that ALREADY HAVE a Nevada Business License)*

Per NAC 631.045 A licensed dentist who owns a dental office or facility must, upon renewal, identify certain staff involved in infection control, and attest to their proper training and qualifications under applicable guidelines.

Do you employ dental auxiliaries (dental hygienists, dental therapists, expanded function dental assistants, and dental assistants)?

☐ No → If selected, answer question (a) by selecting the reason for not having any dental auxiliaries and move to next section.

☐ Yes → If selected, answer question (b) and attest to statement (c).

a) Reason: ☐ Independent Contractor ☐ Instructor ☐ Out of State/ Country ☐ I provide these services ☐ Employee of Practice ☐ Other

Other Reason: _____

b) I certify that each person listed below is so employed as a dental auxiliary:

Employee Name	Employee Title	Date of Employment

**If you have more employees that work as dental auxiliaries than lines provided above, please list them on a separate sheet of paper and attach to the application.*

C. NEVADA BUSINESS LICENSE REPORT AND AUXILIARIES CONTINUED

c) ☐ **By selecting this box,** I attest that each such employee has received adequate instruction in all of the following:

1) radiographic procedures,
2) current CPR training,
3) required continuing education in infection control (a minimum of four (4) hours of continuing education in infection control every two (2) years);
4) and (prior to employment) a copy of chapters 631 of NAC and NRS.

D. CPR CERTIFICATION

New CPR dates: Begin: MM/ DD/ YYYY End: MM/ DD/ YYYY

☐ **By selecting this box,** I hereby affirm and attest that I have attended in person and taken a CPR course (not online) including an actual administration demonstration, and I have entered valid dates of CPR certification on this form. I understand that all certifications for CPR issued by certified instructors must be maintained for a minimum of three (3) years and may be audited by the Board pursuant to NAC 631.177.

E. CONTINUING EDUCATION

1. Have you held your Nevada dental professional license for at least two (2) years? (if yes, you must answer questions (a) and (b) below): ☐ Yes ☐ No

   a) Have you failed to submit proof of completing a 2-hour Screening, Brief Intervention, and Referral to Treatment (SBIRT) approach course to the Board? (If yes, you may submit your SBIRT course-completion certificate if you have completed the course. If you have not completed the course, you will be required to provide this certificate upon your next renewal. SBIRT courses only need to be submitted once). ☐ Yes ☐ No

   b) Have you failed to submit proof of completing a 4-hour Bioterrorism course to the Board? (If yes, submit your Bioterrorism course-completion certificate with your renewal. Bioterrorism courses only need to be submitted once. Failure to submit the Bioterrorism course-completion certificate will prevent your renewal from being processed). ☐ Yes ☐ No

2. Licensees may use the far-right column in the table below to track their continuing education (CE) hours for the current biennial period and determine whether they meet the minimum requirements. To complete this section, licensees must affirm that they have completed all required CE hours by signing in the area below. Completion of the table is optional.

CE Requirements	Dentist Hours Needed	Dental Hygienist Hours Needed	Licensee CE Hours *(Enter your hours below)*
Total CE Hours:	40	30	
Clinical CE Hours:	30	24	
Live-Instruction (webinar/in-person) CE Hours:	20	15	
Infection Control Hours:	4	4	
**If you have a license or permit that requires additional CE hours to be completed, you must enter those hours below:*			
***Sedation/Anesthesia Hours:**	6	N/A	
***DEA/Controlled Substance Hours:**	2	N/A	
***Special Endorsement Immunizations:**	2	2	

By signing the below, I hereby affirm and attest that I have completed all required continuing education hours through Board-recognized providers in accordance with NAC 631.173 and NRS 631.342 and understand that certificates of completion must be retained for at least three (3) years and are subject to audit pursuant to NAC 631.177.

Signature: _____ Date: _____

F. PUBLIC HEALTH ENDORSED HYGIENISTS *(for Dental Hygienists ONLY – NOT DENTISTS)*

A Public Health Endorsed Dental Hygienist may practice outside the scope of NAC 631.210 and NAC 631.220 only while actively affiliated with and/or employed through a Board-approved Public Health Program. A hygienist may not exercise the expanded scope once they are not affiliated or employed with that approved program. If a Public Health Program withdraws its affiliation or employment, the hygienist's Public Health Endorsement will become inactive (latent) until affiliation with an approved program is reestablished.

a) Do you have a Public Health Dental Hygienist Endorsement? (If No, skip to Section G) ☐ Yes ☐ No

b) Do you wish to renew your Public Health Dental Hygienist Endorsement? (If No, skip to Section G) ☐ Yes ☐ No

If yes, list the name(s) of the Public Health Programs with whom you are affiliated and/or employed. If you did not exercise the expanded scope under your Public Health Endorsement, write "N/A."

Name of Affiliated Public Health Program	Public Health Program Address

**If you have more Public Health Programs with whom you are affiliated and/or employed than allowed in the space provided above, please list them on a separate sheet of paper and attach to application*

c) Do you supervise any dental assistants and/or expanded function dental assistants when utilizing your Public Health Endorsement? (If No, skip to question (d)) ☐ Yes ☐ No

If yes, list the name(s) of all dental assistants and expanded function dental assistants you supervised while utilizing your Public Health Endorsement:

Assistant's Name	Title	Date Supervision Began

**If you supervise more people than lines provided above, please list their names, title, and the date you began supervising on a separate sheet of paper and attach to application.*

By signing the below, I hereby affirm and attest that all dental assistants and expanded function dental assistants whom I supervise(d) as listed above are qualified to assist in radiographic and infection control procedures pursuant to NAC 631.260.

Signature: _____ Date: _____

d) ☐ **By selecting this box,** I acknowledge that, pursuant to NAC 631.145, renewal of my Public Health Endorsement is contingent upon the Nevada State Board of Dental Examiners receiving, directly from my affiliated public health program(s), a practitioner's report of the services I performed under the authority of my Public Health Endorsement.

G. AFFIDAVIT

1. Have you had any claims or complaints of malpractice filed against you, any felony or misdemeanor convictions or charges brought against you, or had any professional license suspended, revoked or been subject to probation (whether by this agency or another licensing jurisdiction) during your current licensing period? (If yes, provide a written statement outlining the facts made against you) ☐ Yes ☐ No

2. Are you subject to court order for the support of one or more children (i.e. do you have a child support order?)? (If yes, you MUST answer question (a) below): ☐ Yes ☐ No

   a) Are you in compliance with the court order or a plan approved by the District Attorney or other public agency enforcing the order for the payment or the amount owed pursuant to the court order for the support of one or more children? ☐ Yes ☐ No
   (IF YOU ARE NOT IN COMPLIANCE, YOU MUST NOTIFY US IN WRITING OF YOUR NON-COMPLIANCE AND THE RELEVANT DETAILS)

3. Have you failed to comply with any provision of NRS 631 or NAC 631 (Nevada governing laws)? (If yes, provide a written statement outlining which laws were violated and the relevant details) ☐ Yes ☐ No

4. Do you have any substance use addictions which would impair your ability to practice your dental profession pursuant to NRS 631 or NAC 631? (If yes, provide a written statement outlining your addictions and the relevant details) ☐ Yes ☐ No

5. Do you utilize laser radiation in the performance of your professional duties? (If yes, you MUST submit certification documents with your renewal, pursuant to NAC 631.033) ☐ Yes ☐ No

6. Do you inject neuromodulators that are derived from clostridium botulinum, dermal and soft tissue fillers to patients? (If yes, you must submit certification documents of a Board-approved certification course in neuromodulators (derived from *Clostridium botulinum*) and dermal and soft tissue fillers with your renewal, pursuant to NAC 631.257) ☐ Yes ☐ No

7. Do you have a valid controlled substance permit with the Nevada State Board of Pharmacy? (If yes, you MUST answer question (a) and (b) below): ☐ Yes ☐ No

   a) Have you conducted a minimum of one self-query annually?: ☐ Yes ☐ No

   Date of 1st report MM/ DD/ YYYY Date of 2nd report: MM/ DD/ YYYY DEA No. _____

   b) ☐ **By selecting this box,** I hereby affirm and attest that I have completed the required two (2) hours of continuing education with a recognized provider for the abuse and misuse of controlled substances. I understand that all continuing education certificates of completion issued by recognized providers must be maintained for a minimum of three (3) years and may be audited by the Board pursuant to NAC 631.177.

8. I attest by signing my initials that I am aware of the mandatory requirement to report child abuse and neglect in accordance with the laws of the State of Nevada. _____ Initials

9. I attest by signing my initials that I will self-report any unusual activity occurring during or close in time to my delivery of services (including but not limited to patient deaths, serious patient harm, any act resulting in a medical malpractice lawsuit, and any criminal arrest or conviction). _____ Initials

By signing below, I hereby affirm and attest under penalty of perjury that I have answered the above questions truthfully, accurately, and by me personally, the licensee so named on this form and so stating that all answers provided herein are provided willfully. I further state that I authorize and empower the Nevada State Board of Dental Examiners or its agents, staff, or appointed authority to contact any person, firm, service, agency, entity, or the like to obtain information deemed necessary or desirable by the Board to verify any information contained in my license renewal application and affidavit.

Signature: _____ Date: _____

H. RENEWAL FEES

IF YOU ARE RENEWING YOUR APPLICATION PAST THE DATE AS REQUIRED PER NRS 631.330 YOU SHALL BE ASSESSED A SUSPENDED LICENSE REINSTATEMENT FEE IN ADDITION TO YOUR RENEWAL FEE

DENTIST			
☐ General Dentist	$600.00	☐ Specialty Dentist	$600.00
☐ Restricted Geographical Dentist	$600.00	☐ Suspended License	$300.00
DENTAL HYGIENIST			
☐ Registered Dental Hygienist	$300.00	☐ Restricted Geographical	$300.00
☐ Suspended License	$300.00		
DENTAL THERAPIST			
☐ Dental Therapist	$600.00	☐ Restricted Geographical	$600.00
☐ Suspended License	$300.00		
EXPANDED FUNCTION DENTAL ASSISTANT			
☐ EFDA	$100.00	☐ Restricted Geographical	$100.00
☐ Suspended License	$120.00		
OPTIONAL REQUEST FEES			
☐ Duplicate Wall Cert	$25.00 Quantity: _____	☐ Name Change	$25.00

PAYMENT METHOD

Payment Method: ☐ Check/Money Order (attach with application) ☐ Credit*/Debit Card (credit cards will incur a 3% surcharge)				**Total Amount Authorized**
Name on Card:	Card Number - - -			
Card Billing Address:	Exp Date:	CVV:		
Street:	City:	State:	Zip:	$

***A 3% surcharge is assessed for credit card payments**

By signing below, I acknowledge and agree that, once payment is made, I will not be entitled to a refund of any amount, even if I change my mind about renewing my State of Nevada professional dental license. I understand that the money paid with the renewal application compensates the Board for staff time associated with processing the renewal application, which occurs whether or not I ultimately benefit from my State of Nevada professional dental license.

Signature: _____ Date: _____