



**UTAH DEPARTMENT  
OF COMMERCE**  
Division of Professional Licensing

**Upgrade to:  
Dental Hygienist with Local Anesthesia**

**APPLICANT INFORMATION**

Full Legal Name: \_\_\_\_\_  
First Middle Last

All Previous Legal Names: \_\_\_\_\_

Other DOPL Licenses Held: \_\_\_\_\_

SSN:\* \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Gender:  Male  Female  
*\* If you don't have a social security number, please follow the instructions on the last page.*

Address: \_\_\_\_\_  
Street Address (including Apt/Unit/Ste #) and/or PO Box

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_ Email: \_\_\_\_\_  
*Note: All Division notices and communication will be sent to this email.*

Please select one:

- I am a United States citizen or a non-citizen of the United States who is lawfully present.
- I am a foreign national not physically present in the United States.
- None of the above, please explain: \_\_\_\_\_

Driver License or State ID Card: \_\_\_\_\_  
State of Issue License Number Expiration Date

**NOTE:** If you do not hold a US Driver License or a US State ID, you must present a legible copy of your current and valid government issued document(s) showing evidence of lawful presence in the United States.

**AFFIDAVIT AND RELEASE**

I certify that to the best of my knowledge, the information contained in the application and all supporting document(s) are true and correct, and discloses all material facts regarding the applicant, and that I will update or correct the application as necessary, prior to any action on my application.

I authorize all persons, organizations, governmental agencies, or any others not specifically listed, which are set forth directly or by reference in this application, to release to the Department of Commerce, State of Utah, any files, records, or information of any type reasonably required for the Department to properly evaluate my qualifications for licensure/certification/registration by the State of Utah.

I understand that it is the continuing responsibility of applicants and licensees to read, understand, and apply the requirements contained in all statutes and rules pertaining to the occupation or profession for which I am applying, and that failure to do so may result in civil, administrative, or criminal sanctions.

I understand that I am responsible to update the Department of any changes relating to my application/license/certification/registration.

I understand that if the application is not complete at the time of submission, it will delay approval and could result in a denial.

**I declare under criminal penalty under the law of Utah that this application is true and correct.**

Signature of Applicant: \_\_\_\_\_ Date: \_\_\_\_\_



**QUALIFYING QUESTIONNAIRE**

**Do not leave any question blank.**

*DOPL may request additional documentation if the information submitted is insufficient.*

1.  Yes  No Have you EVER had a license, certificate, permit, or registration to practice a regulated profession denied, conditioned, curtailed, limited, restricted, suspended, revoked, reprimanded, resigned, or surrendered while under investigation, or otherwise **disciplined in any way**?
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2.  Yes  No Do you CURRENTLY have **any criminal action active or pending**?
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3.  Yes  No WITHIN THE PAST 10 YEARS, have you pled **guilty** to, **no contest** to, entered into a **plea in abeyance**, or been **convicted** of a **misdemeanor** in any jurisdiction?
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4.  Yes  No Have you EVER pled **guilty** to, **no contest** to, entered into a **plea in abeyance**, or been **convicted** of a felony in any jurisdiction?

If you answered "Yes" to any of the above questions, enclose with this application complete information with respect to all circumstances and the final result, if such has been reached. If you answered "Yes" to questions 2, 3, or 4 you must submit the following for EACH and EVERY incident:

- **personal account of the incident**
- **police report(s)**
- **court record(s)**
- **probation/parole officer report(s)**

If you are unable to obtain any of the records required above, you must submit documentation on official letterhead from the police department and/or court indicating that the information is no longer available.

Please **DISCLOSE** the following:

- charges that were later held in abeyance (plea in abeyance), diverted, reduced, or dismissed.
- motor vehicle offenses such as driving while impaired or intoxicated.
- if you are restricted from possession, purchase, transfer, or ownership of a firearm or ammunition (even if your restriction is based on a non-reportable juvenile conviction).

You do **NOT** need to disclose:

- minor traffic offenses such as parking or speeding violations.
- juvenile offenses, unless you were tried as an adult.
- legally expunged or sealed criminal history incidents.

For more information, see DOPL's [criminal history FAQs](#).

**PROFESSIONAL LICENSES**

List all other licenses, registrations or certifications issued by any state, which you now hold or have ever held in any profession. *(Use additional sheets if necessary.)*

Profession: \_\_\_\_\_ License Number: \_\_\_\_\_

Issuing State: \_\_\_\_\_ License Status: \_\_\_\_\_ Issue Date: \_\_\_\_\_

Profession: \_\_\_\_\_ License Number: \_\_\_\_\_

Issuing State: \_\_\_\_\_ License Status: \_\_\_\_\_ Issue Date: \_\_\_\_\_

Profession: \_\_\_\_\_ License Number: \_\_\_\_\_

Issuing State: \_\_\_\_\_ License Status: \_\_\_\_\_ Issue Date: \_\_\_\_\_



**MEDICAL QUALIFYING QUESTIONNAIRE**

**Read thoroughly and answer each question. Do not leave any question blank.**

*A "yes" answer does not necessarily mean you will not be granted a license; however, DOPL may request additional documentation if the information submitted is insufficient.*

1. **Have your rights, privileges, and/or participation ever been denied, conditioned, curtailed, limited, restricted, suspended or revoked in any way by:**
  - Yes  No a hospital or health care facility
  - Yes  No Medicaid, Medicare or any other state or federal health care payment reimbursement program
  - Yes  No the Federal Drug Enforcement Administration or any state drug enforcement agency
  - Yes  No malpractice insurance coverage
  - Yes  No other entity: \_\_\_\_\_

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2. **Have you ever been permitted to resign or surrender any rights, privileges and/or participation while under investigation or while action was pending against you from:**
  - Yes  No a hospital or health care facility
  - Yes  No Medicaid, Medicare or any other state or federal health care payment reimbursement program
  - Yes  No The Federal Drug Enforcement Administration or any state drug enforcement agency
  - Yes  No malpractice insurance coverage
  - Yes  No other entity: \_\_\_\_\_

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3. **Is any action pending against you now by:**
  - Yes  No a hospital or health care facility
  - Yes  No Medicaid, Medicare or any other state or federal health care payment reimbursement program
  - Yes  No the Federal Drug Enforcement Administration or any state drug enforcement agency
  - Yes  No malpractice insurance coverage
  - Yes  No other entity: \_\_\_\_\_

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4.  Yes  No **Have you been named as a defendant in a malpractice suit?**

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5.  Yes  No **Have you ever had office monitoring, practice curtailments, individual surcharge assessments based upon specific claims history, or other limitation, restrictions or conditions imposed by any malpractice carrier?**

If you answered "Yes" to question 4 you must submit a complete narrative of the circumstances and a National Practitioner Data Bank report outlining all professional liability claims made against your license and any settlements paid by or on your behalf. *NPDB website: <http://www.npdb.hrsa.gov>.*

If you answered "Yes" to any of the above questions, enclose with this application complete information with respect to all circumstances and the final result, if such has been reached.

**NATIONAL PROVIDER IDENTIFIER (NPI)**

Your NPI: \_\_\_\_\_

## APPLICATION CHECKLIST AND INSTRUCTIONS

This checklist is for your convenience, you do not need to include it with your application.

**NOTE: Incomplete applications will be denied.**

Your application is classified as a public record and may be available for inspection by the public, except with regard to the release of information which is sub-classified as controlled, private, or protected under the Government Records Access and Management Act or restricted by other law.

**If you do not have a valid Social Security number**, you must submit your Individual Taxpayer Identification Number (ITIN), Alien Registration Number (A-number), or a copy of an unexpired government issued passport from your country of residence and an intent-to-hire letter from a Utah based employer ([Utah Code § R156-1-301](#)). Submission of the above documents may require additional documents to demonstrate lawful presence ([Utah Code § 63G-12-402 \(3\)\(k\)](#)).

### ALL APPLICANTS

The following items are required to complete your application:

- \$35.00 non-refundable application processing fee, made payable to "DOPL".
- Supporting documentation for any "yes" answers provided on the qualifying questionnaires.
- Copy of your current CPR or BCLS course certification.
- Official letter from your anesthesia course director documenting your successful completion of a program in the administration of local anesthetics accredited by the Commission on Dental Accreditation of the ADA.
- Request an official score report or certificate be released to Utah for the WREB, CDCA, CITA, SRTA or CRDTS Anesthesia Examination.

### Submit completed application to the Division:

By US Postal Service:

**Division of Professional Licensing  
PO BOX 146741  
Salt Lake City, UT 84114-6741**

By in-person or express delivery:

**Division of Professional Licensing  
Heber M Wells Building, 1st Floor  
160 E 300 S  
Salt Lake City, UT 84111**

If you have questions, please contact the Division at 801-530-6628 or by email at [B1@Utah.gov](mailto:B1@Utah.gov).