OREGON BOARD OF DENTISTRY
Unit 23
PO Box 4395
Portland, OR 97208-4395

Rev. Code 2142

APPLICATION FOR DENTAL HYGIENE EXPANDED PRACTICE PERMIT
PATHWAY 2
DENTAL HYGIENIST
Fee: $75.00

Name _____ License No. _____

Mailing Address _____

City _____ State _____ Zip _____

I have successfully completed a course of study approved by the Board that includes at least 500 hours of dental hygiene practice on patients described in ORS 680.205 while under the direct supervision of a member of the faculty of a dental or dental hygiene program accredited by the Commission on Dental Accreditation of the American Dental Association.

Name of Post-secondary Program: _____

Date of Graduation: _____

Hours of practice on patients described in ORS 680.205: _____

Name of Program: _____

Name of Faculty: _____

Hours of practice on patients described in ORS 680.205:_____

Professional Liability Insurance Carrier	Policy Number	Expiration Date

By signing below I certify that I have met all requirements for an Expanded Practice Permit. I further certify that the information given on this form is true and correct. I understand that any falsification could result in denial, suspension, and/or revocation of my dental hygiene license.

Signature _____ Date _____

Oregon
John A. Kitzhaber, MD, Governor

Board of Dentistry
1500 SW 1st Avenue
Suite 770
Portland, OR 97201-5828
(971) 673-3200
Fax: (971) 673-3202
www.oregon.gov/dentistry

DENTAL HYGIENE EXPANDED PRACTICE PERMIT

A licensed dental hygienist who holds a valid, unrestricted Oregon dental hygiene license and who meets the requirements of ORS 680.200 may practice as a Expanded Practice Permit Dental Hygienist after obtaining a permit from the Board.

Instructions – Pathway 2

To obtain an Expanded Practice Permit, complete the application and return it and the fee to the Oregon Board of Dentistry, Unit 23, PO Box 4395, Portland, Oregon 97208-4395.

1. Verification of Practice Hours – Pre-Graduation Education: Verification submitted from a formal, post-secondary educational program accredited by the Commission on Dental Accreditation of the American Dental Association directly to the Board, of the number of hours you practiced on patients described in ORS 680.205 while under the direct supervision of a member of the faculty.

2. Verification of Practice Hours – Post-Graduation - Faculty. Verification submitted from a faculty or adjunct faculty member, directly to the Board, certifying the number of hours you practiced on patients described in ORS 680.205 after graduating from an ADA accredited post-secondary education program while under the direct supervision of a member of the faculty.

3. Verification of Faculty: Verification submitted from the ADA accredited program, directly to the Board, certifying that an individual was/is a faculty or adjunct faculty member.

4. Permit Fee. Fees must be paid in U.S. funds, and submitted with the application form. Applications will not be processed without the appropriate fee. **Fees paid are not refundable (ORS 680.075(8)**.

5. Proof of Health Care Provider BLS/CPR or its Equivalent. Enclose documentation showing that you hold a valid and current Health Care Provider BLS/CPR level or its equivalent certificate.

6. Proof of Professional Liability Insurance. Submit documentation of current professional liability insurance coverage.

7. Collaborative Agreement. An agreement between the expanded practice dental hygienist and a dentist(s) setting forth the agreed-upon scope of the dental hygienist's practice in regards to the following procedures, the agreement must be signed by both parties:

    a. Administering local anesthesia;
    b. Administering temporary restorations without excavation;
    c. Prescribing prophylactic antibiotics and nonsteroidal anti-inflammatory drugs specified in the agreement; and
    d. Overall dental risk assessment and referral parameters.

    A Collaborative Agreement is not required to apply for an Expanded Practice Permit.

Questions? Call Examination and Licensing Manager Teresa Haynes at (971) 673-3200.

VERIFICATION OF PRACTICE HOURS
ADA Accredited Program
Pre-Graduation
Course of Study
Pathway 2

EXPANDED PRACTICE PERMIT
CERTIFICATION OF CLINICAL PRACTICE

Dental Hygienist Name: _____ **License No.** _____

Program Director's Name: _____ **Telephone Number:** _____
Print Name

Dental Hygiene Program: _____

Location/Address: _____
Address City State Zip Code

From _____ **to** _____ **TOTAL HOURS COMPLETED**_____
Date Date

I certify that the above named dental hygienist while in our dental hygiene program, practiced on patients or residents of the following facilities or programs who, due to age, infirmity or disability, were unable to receive regular dental hygiene treatment while under the direct supervision of a faculty member:

Please indicate the category(s) in which the above named dental hygienist practiced:
(Check all that apply)

- ☐ (A) Nursing homes as defined in ORS 678.710;
- ☐ (B) Adult foster homes as defined in ORS 443.705;
- ☐ (C) Residential care facilities as defined in ORS 443.400;
- ☐ (D) Adult congregate living facilities as defined in ORS 441.525;
- ☐ (E) Mental health residential programs administered by the Oregon Health Authority;
- ☐ (F) Facilities for mentally ill persons, as those terms are defined in ORS 426.005;
- ☐ (G) Facilities for persons with mental retardation, as those terms are defined in ORS 427.005;
- ☐ (H) Local correctional facilities and juvenile detention facilities as those terms are defined in ORS 169.005, regional correctional facilities as defined in ORS 169.620, youth correction facilities as defined in ORS 420.005, youth care centers as defined in ORS 420.855, and Department of Corrections institutions as defined in ORS 421.005; or
- ☐ (I) Public and nonprofit community health clinics.
- ☐ (b) Adults who are homebound.
- ☐ (c) Students or enrollees of nursery schools and day care programs and their siblings under 18 years of age, Job Corps and other similar employment training facilities, primary and secondary schools, including private schools and public charter schools, and persons entitled to benefits under the Women, Infants and Children Program.
- ☐ (d) Patients in hospitals, medical clinics, medical offices or offices operated or staffed by nurse practitioners, physician assistants or midwives.
- ☐ (e) Patients whose income is less than the federal poverty level.
- ☐ Other populations that the Oregon Board of Dentistry determines are underserved or lack access to dental hygiene services.

By signing below I certify that the information provided on this form is true and correct.

Signature of Program Director: _____ Date: _____

Return this form directly to the Oregon Board of Dentistry, 1500 SW 1st Avenue, Suite 770, Portland OR 97201.

This form may be duplicated

VERIFICATION OF PRACTICE HOURS
ADA Accredited Program
Post-Graduation
Faculty – Hours Verification
Course of Study
Pathway 2

EXPANDED PRACTICE PERMIT
CERTIFICATION OF CLINICAL PRACTICE

Dental Hygienist Name: _____ **License No.** _____

Supervising Faculty Name: _____ **Telephone Number:** _____
Print Name

Dental or Dental Hygiene Program: _____

Location/Address: _____
Address City State Zip Code

From _____ **to** _____ **TOTAL HOURS WORKED**_____
Date Date

I certify that while I was a faculty member or an adjunct faculty member, for the program named above, and while under my direct supervision, the above dental hygienist practiced on patients or residents of the following facilities or programs who, due to age, infirmity or disability, were unable to receive regular dental hygiene treatment:

Please indicate the catagory(s) in which the above named dental hygienist practiced:
(Check all that apply)

- ☐ (A) Nursing homes as defined in ORS 678.710;
- ☐ (B) Adult foster homes as defined in ORS 443.705;
- ☐ (C) Residential care facilities as defined in ORS 443.400;
- ☐ (D) Adult congregate living facilities as defined in ORS 441.525;
- ☐ (E) Mental health residential programs administered by the Oregon Health Authority;
- ☐ (F) Facilities for mentally ill persons, as those terms are defined in ORS 426.005;
- ☐ (G) Facilities for persons with mental retardation, as those terms are defined in ORS 427.005;
- ☐ (H) Local correctional facilities and juvenile detention facilities as those terms are defined in ORS 169.005, regional correctional facilities as defined in ORS 169.620, youth correction facilities as defined in ORS 420.005, youth care centers as defined in ORS 420.855, and Department of Corrections institutions as defined in ORS 421.005; or
- ☐ (I) Public and nonprofit community health clinics.
- ☐ (b) Adults who are homebound.
- ☐ (c) Students or enrollees of nursery schools and day care programs and their siblings under 18 years of age, Job Corps and other similar employment training facilities, primary and secondary schools, including private schools and public charter schools, and persons entitled to benefits under the Women, Infants and Children Program.
- ☐ (d) Patients in hospitals, medical clinics, medical offices or offices operated or staffed by nurse practitioners, physician assistants or midwives.
- ☐ (e) Patients whose income is less than the federal poverty level.
- ☐ Other populations that the Oregon Board of Dentistry determines are underserved or lack access to dental hygiene services.

By signing below I certify that the information provided on this form is true and correct.

Signature of Faculty: _____ Date: _____

Return this form directly to the Oregon Board of Dentistry, 1500 SW 1st Avenue, Suite 770, Portland OR 97201.

This form may be duplicated

Rev. 12/2013

VERIFICATION OF FACULTY OR ADJUNCT FACULTY MEMBER
FROM ADA ACCREDITED PROGRAM
PATHWAY 2

Dental or Dental Hygiene Program: _____

Location/Address: _____

Telephone: _____

Faculty or Adjunct Faculty Name: _____

Faculty Employed/Appointment Date(s): From _____ to _____.

By signing below I certify that the information provided on this form is true and correct.

_____
Program Director's Signature

_____
Type or Print Name

_____
Date

Return this form directly to the Oregon Board of Dentistry, 1500 SW 1st Avenue, Suite 770, Portland, OR 97201.

Dental Hygiene Expanded Practice Permit

680.200 Issuing permit; requirements. (1) Upon application accompanied by the fee established by the Oregon Board of Dentistry, the board shall grant a permit to practice as a expanded practice permit dental hygienist to any applicant who:

(a) Holds a valid, unrestricted Oregon dental hygiene license;

(b) Presents proof of current professional liability insurance coverage;

(c) Presents documentation satisfactory to the board of successful completion of an emergency life support course for health professionals, including cardiopulmonary resuscitation, from an agency or educational institution approved by the board; and

(d) Presents documentation satisfactory to the board that the applicant has:

(A)(i) Completed 2,500 hours of supervised dental hygiene practice; and

(ii) After licensure as a dental hygienist, completed 40 hours of courses, chosen by the applicant, in clinical dental hygiene or public health sponsored by continuing education providers approved by the board; or

(B) Completed a course of study approved by the board that includes at least 500 hours of dental hygiene practice, completed before or after graduation from a dental hygiene program, on patients described in ORS 680.205 while under the direct supervision of a member of the faculty of a dental program or dental hygiene program accredited by the Commission on Dental Accreditation of the American Dental Association or its successor agency.

(2) A permit issued pursuant to subsection (1) of this section expires two years following the date of issuance unless renewed on or before that date by:

(a) Payment of the renewal fee as set by the board;

(b) Submission to the board of satisfactory evidence of completion of at least 36 hours of continuing education; and

(c) Presentation to the board of proof of professional liability insurance coverage; and

(d) Completion of a survey developed by the board that measures the success of the expanded practice dental hygienist program against baseline data.

(3) The board may refuse to issue or renew an expanded practice dental hygienist permit or may suspend or revoke the permit of an expanded practice dental hygienist who has been convicted of an offense or been disciplined by a dental licensing body in a manner that bears, in the judgment of the board, a demonstrable relationship to the ability of the applicant to practice expanded practice dental hygiene in accordance with the provisions of this chapter or ORS chapter 679, or who has falsified an application for permit, or any person for any cause described under ORS 679.140 or 679.170.

680.205 Services rendered under permit. (1) An expanded practice dental hygienist may render all services within the scope of practice of dental hygiene, as defined in ORS 679.010, without the supervision of a dentist and as authorized by the expanded practice dental hygienist permit to:

(a) Patients or residents of the following facilities or programs who, due to age, infirmity or disability, are unable to receive regular dental hygiene treatment:

(A) Nursing homes as defined in ORS 678.710;

(B) Adult foster homes as defined in ORS 443.705;

(C) Residential care facilities as defined in ORS 443.400;

(D) Adult congregate living facilities as defined in ORS 441.525;

(E) Mental health residential programs administered by the Oregon Health Authority;

(F) Facilities for mentally ill persons, as those terms are defined in ORS 426.005;

(G) Facilities for persons with mental retardation, as those terms are defined in ORS 427.005;

(H) Local correctional facilities and juvenile detention facilities as those terms are defined in ORS 169.005, regional correctional facilities as defined in ORS 169.620, youth correction facilities as defined in ORS 420.005, youth care centers as defined in ORS 420.855, and Department of Corrections institutions as defined in ORS 421.005; or

(I) Public and nonprofit community health clinics.

(b) Adults who are homebound.

(c) Students or enrollees of nursery schools and day care programs and their siblings under 18 years of age, Job Corps and other similar employment training facilities, primary and secondary schools, including private schools and public charter schools, and persons entitled to benefits under the Women, Infants and Children Program.

(d) Patients in hospitals, medical clinics, medical offices or offices operated or staffed by nurse practitioners, physician assistants or midwives.

(e) Patients whose income is less than the federal poverty level.

(f) Other populations that the Oregon Board of Dentistry determines are underserved or lack access to dental hygiene services.

(2) At least once each calendar year, an expanded practice dental hygienist shall refer each patient or resident to a dentist who is available to treat the patient or resident.

(3) An expanded practice dental hygienist may render the services described in paragraphs (a) to (d) of this subsection to the patients described in subsection (1) of this section if the expanded practice dental hygienist has entered into an agreement in a format approved by the board with a dentist licensed under ORS chapter 679. The agreement must set forth the agreed-upon scope of the dental hygienist's practice with regard to:

(a) Administering local anesthesia;
(b) Administering temporary restorations without excavation;
(c) Prescribing prophylactic antibiotics and nonsteroidal anti-inflammatory drugs specified in the agreement; and
(d) Overall dental risk assessment and referral parameters.

(4) This section does not authorize an expanded practice dental hygienist to administer nitrous oxide except under the indirect supervision of a dentist licensed under ORS chapter 679.

(5) An expanded practice dental hygienist may assess the need for and appropriateness of sealants, apply sealants and write prescriptions for all applications of fluoride in which fluoride is applied or supplied to patients.

(6) An expanded practice dental hygienist must also procure all other permits or certificates required by the board under ORS 679.250.

Expanded Practice Permit
Practice Settings

Name: _____ License Number: _____

Please indicate the location(s) in which you plan to practice:
(Check all that apply)

(a) Patients or residents of the following facilities or programs who, due to age, infirmity or disability, are unable to receive regular dental hygiene treatment:

☐ (A) Nursing homes as defined in ORS 678.710;

☐ (B) Adult foster homes as defined in ORS 443.705;

☐ (C) Residential care facilities as defined in ORS 443.400;

☐ (D) Adult congregate living facilities as defined in ORS 441.525;

☐ (E) Mental health residential programs administered by the Oregon Health Authority;

☐ (F) Facilities for mentally ill persons, as those terms are defined in ORS 426.005;

☐ (G) Facilities for persons with mental retardation, as those terms are defined in ORS 427.005;

☐ (H) Local correctional facilities and juvenile detention facilities as those terms are defined in ORS 169.005, regional correctional facilities as defined in ORS 169.620, youth correction facilities as defined in ORS 420.005, youth care centers as defined in ORS 420.855, and Department of Corrections institutions as defined in ORS 421.005; or

☐ (I) Public and nonprofit community health clinics.

☐ (b) Adults who are homebound.

☐ (c) Students or enrollees of nursery schools and day care programs and their siblings under 18 years of age, Job Corps and other similar employment training facilities, primary and secondary schools, including private schools and public charter schools, and persons entitled to benefits under the Women, Infants and Children Program.

☐ (d) Patients in hospitals, medical clinics, medical offices or offices operated or staffed by nurse practitioners, physician assistants or midwives.

☐ (e) Patients whose income is less than the federal poverty level.

☐ General/Specialty Practice.

☐ Not currently practicing.

Signature: _____ Date: _____

Oregon Board of Dentistry

Expanded Practice Dental Hygiene Permit

Verification of Collaborative Agreement

I _____, License No. _____ have entered into a collaborative agreement with _____, a dental hygienist with an expanded practice permit, License No. _____. The collaborative agreement sets forth the agreed-upon scope of the dental hygienist's practice with regard to the following:

Check all that apply:

☐ Administer local anesthesia.

☐ Administer temporary restorations without excavation.

☐ Prescribing prophylactic antibiotics and non-steroidal anti-inflammatory drugs:

* On your Collaborative Agreement you must specify either ALL prophylactic antibiotics or non-steroidal anti-inflammatory drugs, or if limiting prescribing abilities, list specific drugs allowed.

☐ Overall dental risk assessment and referral parameters.

I understand that this agreement will remain in effect with the Oregon Board of Dentistry (OBD) until I submit a written change. If any changes are made to this agreement, a new verification and copy of the agreement must be submitted to the OBD immediately.

I attest that a copy of the Collaborative Agreement, signed by both parties, **is attached to this verification.** I understand that failure to provide a copy of the agreement with the verification will result in the verification form being rejected and returned.

Dentist's Signature: _____ Date: _____

Dental Hygienist's Signature: _____Date: _____