



HEALTH LICENSING OFFICE
Board of Denture Technology

1430 Tandem Ave. NE, Suite 180, Salem OR 97301
 Phone: 503-378-8667 | Fax: 503-370-9004
healthoregon.org/hlo | Email: hlo.info@state.or.us

DENTURIST PERMANENT LICENSURE APPLICATION

1. Applicant Information

APPLICANT NAME: LAST FIRST MIDDLE INITIAL

RESIDENTIAL PHYSICAL ADDRESS (REQUIRED)

CITY STATE ZIP

MAILING ADDRESS (IF DIFFERENT FROM RESIDENTIAL ADDRESS)

CITY STATE ZIP

PHONE: HOME CELL BUSINESS TELEPHONE EMAIL

GENDER BIRTHDATE SOCIAL SECURITY NUMBER (REQUIRED)
 Female Male

Have you ever been known under any other name?
 No Yes – If yes, list full name(s):

Do you hold or have you previously held licensure, certification or registration with the Health Licensing Office or any other state? No Yes - If yes, please list information below.

State: Lic./Cert./Reg.# Expiration:

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State: Lic./Cert./Reg.# Expiration:

Do not write in this section – Official use only

INITIALS _____ OTC ID VERIFIED Qualified exam: Written Practical Re-exam

Method of Payment: <input type="checkbox"/> Visa <input type="checkbox"/> MasterCard <input type="checkbox"/> Discover <input type="checkbox"/> Cash <input type="checkbox"/> Check <input type="checkbox"/> MO <input type="checkbox"/> PO AMOUNT: _____ INITIALS: _____ <input type="checkbox"/> APPROVAL CODE/CK# _____	Method of Payment: <input type="checkbox"/> Visa <input type="checkbox"/> MasterCard <input type="checkbox"/> Discover <input type="checkbox"/> Cash <input type="checkbox"/> Check <input type="checkbox"/> MO <input type="checkbox"/> PO AMOUNT: _____ INITIALS: _____ <input type="checkbox"/> APPROVAL CODE/CK# _____	Method of Payment: <input type="checkbox"/> Visa <input type="checkbox"/> MasterCard <input type="checkbox"/> Discover <input type="checkbox"/> Cash <input type="checkbox"/> Check <input type="checkbox"/> MO <input type="checkbox"/> PO AMOUNT: _____ INITIALS: _____ <input type="checkbox"/> APPROVAL CODE/CK# _____
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2. Individual Records Questions: Please accurately answer all of the questions below. The Office may review your information through the Law Enforcement Data System, other governmental agencies, and private vendors to confirm the accuracy of the information. Any misrepresentation or failure to disclose information may result in disciplinary action.

● Are you now, or have you ever been, the subject of any active or inactive disciplinary action or voluntary resignation of a professional license, certificate, registration or permit imposed by a licensing or regulatory authority in this or any other state? Disciplinary action includes, but is not limited to, probation, suspension, civil penalty, or any other sanction limiting, in any way, a license, certificate, registration or permit. **Yes** **No** If yes, please explain (**attach additional pages if necessary**):

<p>● Have you ever been convicted of a misdemeanor or felony? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please list all convictions, including the charges as stated in the court documents and year convicted (attach additional pages if necessary).</p>	Year Convicted

● As of today are you on probation or parole? **Yes** **No** If yes, you **must** provide a letter of release from your probation or parole officer authorizing you to obtain an authorization to practice. If you are on bench probation, or probation with the court, you must provide documentation of your conditions of the probation.

As part of your application for initial or renewed occupational or professional license, certification, or registration issued by the Health Licensing Office, you are required to provide your Social Security number (SSN) to the Office. This is mandatory. The authority for this requirement is ORS 25.785, ORS 305.385, 42 USC §405(c)(2)(C)(i), 42 USC § 666(a)(13), and 41 CFR 61.7. Failure to provide your SSN will be a basis to refuse to issue or renew the license, certification, or registration you seek. This record of your SSN is used for child support enforcement and tax administration purposes (including identification). The HLO will use your SSN for these purposes only, unless you authorize other uses of the number. Your SSN will remain on file with the Office.

I have examined this application and certify that it is true, correct, and complete. I understand that knowingly making a false statement on this application will be cause for denial, suspension, or revocation of my license, certification or registration. I have enclosed the required fees and documentation.

Applicant Signature:	Date:
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ORS 181.534, 670.280, 676.608, and 676.612 authorize the Health Licensing Office to conduct criminal background checks and the office requests that you voluntarily provide your Social Security number for this purpose. I understand my application may be subject to a criminal background check.

Before issuing a default final order, the Health Licensing Office must determine the military status of a Respondent, under 50 USC App § 521(b) (Supp. 2005). Your Social Security Number may be used in order to verify your military status (or lack thereof).

If any disciplinary action is taken against your license, certification, or registration, your Social Security Number may be reported to the federal Health Care Integrity and Protection Data Bank (NPDB) under Title IV of Public Law 99-660, the Health Care Quality Improvement Act of 1986 (Title IV); Section 1921 of the Social Security Act (Section 1921); Section 1128E of the Social Security Act (Section 1128E); and their implementing regulations found at 45 CFR Part 60.

I hereby voluntarily consent to disclose my Social Security number to the HLO for criminal background checks, verification of military status, and reports to the Health Care Integrity and Protection Data Bank. Failure to provide your Social Security number for these purposes will not be used as a basis to deny your application, or to deny you any right, benefit or privilege provided by law. If you consent to the use of your Social Security number by the HLO for these purposes, it may be used only for these purposes.

Applicant Signature:	Date:
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3. * (Complete This Section Only If Submitting Payment By Mail) *****

Method Of Payment For Application Fee = \$350 (qualification through pathway one or two); \$450 (qualification through pathway three); License Fee = \$350

Please check one: Cash Check Money order Purchase order Credit card (see below)

Type of Credit Card: Visa MasterCard Discover (Cardholder must either be the applicant or be present at the time application is submitted) **Do Not Fax or Email Credit Card Information**

Name on card: _____

Card number: _____ Exp: _____ Authorized amount: \$ _____

Cardholder signature: _____

4. Affirmative Action – Voluntary Question

The State of Oregon has an Affirmative Action Policy. If you choose to provide this information, it will help us evaluate the effectiveness of our affirmative action programs. This information will also be used in the aggregate (i.e. as a whole, not individually) for research and statistical purposes. It will not be tied specifically or directly to your licensing information.

Ethnic Background (check only one)

- (A) **Asian or Pacific Islander:** Persons having origins in any of the peoples of the Far East, Southeast Asia, the Indian subcontinent, or the Pacific Islands. This area includes, for example, China, Japan, Korea, the Philippine Islands and Samoa.
- (B) **African American (not of Hispanic origin):** Persons having origins in any of the Black racial groups of Africa.
- (H) **Hispanic:** Persons of Mexican, Puerto Rican, Cuban, Central or South American or other Spanish cultures or origin, regardless of race.
- (I) **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.
- (W) **Caucasian (not of Hispanic origin):** Persons having origins in any of the original peoples of Europe, North Africa or the Middle East.

REQUIREMENTS FOR DENTURE TECHNOLOGY PERMANENT LICENSE APPLICATION

- Meet the requirements of OAR 331 division 30;
- Submit a completed application form prescribed by the HLO, which must contain the information listed in OAR 331-030-0000 and be accompanied by payment of the required application fees = **\$350 (for qualification through pathway one or two); OR \$450 (for qualification through pathway three); and** payment of the required license fees = **\$350 (see method of payment section above);**
- Submit **two** forms of acceptable identification as listed in OAR 331-030-0000(8), **both of which must include applicant's current legal name.** Front and back of legible (clear) photocopies if submitted by mail. **Pursuant to OAR 331-030-0000(10) at least one form of identification must be photographic; driver license, state ID card, passport or military ID card;**
- Provide documentation of completing a qualifying pathway (See qualifying pathways below).

PATHWAY ONE: QUALIFICATION THROUGH ASSOCIATE'S DEGREE PROGRAM OR EQUIVALENT EDUCATION WITH 1,000 HOURS SUPERVISED CLINICAL PRACTICE IN DENTURE TECHNOLOGY WITHIN AN EDUCATIONAL PROGRAM.

Applicant must:

- Submit official transcripts, as defined in OAR 331-405-0020, demonstrating completion of an HLO approved Associate's degree in denture technology or equivalent education listed under OAR 331-407-0000. The official transcript must document completion of 1,000 hours supervised clinical practice defined under OAR 331-405-0020(9);
- Have completed and passed a Board approved practical examination within two years before the date of application; and
- Have completed and passed a Board approved written examination within two years before the date of application.

NOTE: An applicant is not required to provide official transcript or proof of having completed and passed a Board approved written examination if the applicant obtained a denture technology temporary license within two years from the date of application for a full denture technology license.

(OR)

PATHWAY TWO: QUALIFICATION THROUGH ASSOCIATE'S DEGREE PROGRAM OR EQUIVALENT EDUCATION WITH 1,000 HOURS SUPERVISED CLINICAL PRACTICE IN DENTURE TECHNOLOGY UNDER AN APPROVED SUPERVISOR.

Applicant must:

- Submit official transcript, as defined in OAR 331-405-0020, demonstrating completion of an HLO approved Associate's degree in denture technology or equivalent education listed under OAR 331-407-0000;
- Submit documentation of 1,000 hours supervised clinical practice defined under OAR 331-405-0020(9) under an approved supervisor on a form prescribed by the HLO;
- Have completed and passed a Board approved practical examination within two years before the date of application; and
- Have completed and passed a Board approved written examination within two years before the date of application.

NOTE: An applicant is not required to provide official transcript, documentation of 1,000 hours supervised clinical practice under an approved supervisor or proof of having completed and passed a Board approved written examination if the applicant obtained a denture technology temporary license within two years from the date of application for a full denture technology license.

(OR)

PATHWAY THREE: RECIPROCITY

Applicant must:

- Submit official transcript or transcripts as defined in OAR 331-405-0020 demonstrating completion of qualifying Associate's degree or equivalent education, as described in OAR 331-410-0010;
- Submit an affidavit of licensure pursuant to OAR 331-405-0020(1), demonstrating proof of current licensure as a dentist, which is active with no current or pending disciplinary action. The license must have been issued by another state, the District of Columbia, a United States Territory, or Canada, and that jurisdiction's dentist licensing standards must be substantially equivalent to those of Oregon, as determined by the HLO;
- Have successfully passed both written and practical dentist examinations, which are substantially equivalent to those required for licensure in Oregon, as determined by the HLO; and
- Submit documentation of having engaged in full-time dentist practice in the applicant's reciprocal licensure jurisdiction for at least two years immediately before the date of application for licensure in Oregon, on a form prescribed by the HLO.



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LISTING OF SCHOOL(S) ATTENDED APPLICABLE TO DENTURE TECHNOLOGY

Documentation to prove completion of an Associate Degree program in denture technology or the equivalent program, shall be official school transcripts from HLO approved schools, and may include published course outlines showing that training included curriculum objectives as determined by the HLO and the board. "Official transcript" as defined in OAR 331-405-0020 (8) means an original document certified by a school or educational institution.

APPLICANT NAME: LAST		FIRST	MIDDLE INITIAL	
NAME OF SCHOOL	SCHOOL LOCATION		ENROLLMENT DATES FROM: _____ TO: _____	WILL HLO BE RECEIVING A TRANSCRIPT FROM THIS SCHOOL? <input type="checkbox"/> YES <input type="checkbox"/> NO
COURSE OF STUDY	SEMESTER/QUARTER HOURS EARNED	DEGREE EARNED? <input type="checkbox"/> YES <input type="checkbox"/> NO	DATE GRADUATED	TYPE OF DEGREE RECEIVED
NAME OF SCHOOL	SCHOOL LOCATION		ENROLLMENT DATES FROM: _____ TO: _____	WILL HLO BE RECEIVING A TRANSCRIPT FROM THIS SCHOOL? <input type="checkbox"/> YES <input type="checkbox"/> NO
COURSE OF STUDY	SEMESTER/QUARTER HOURS EARNED	DEGREE EARNED? <input type="checkbox"/> YES <input type="checkbox"/> NO	DATE GRADUATED	TYPE OF DEGREE RECEIVED
NAME OF SCHOOL	SCHOOL LOCATION		ENROLLMENT DATES FROM: _____ TO: _____	WILL HLO BE RECEIVING A TRANSCRIPT FROM THIS SCHOOL? <input type="checkbox"/> YES <input type="checkbox"/> NO
COURSE OF STUDY	SEMESTER/QUARTER HOURS EARNED	DEGREE EARNED? <input type="checkbox"/> YES <input type="checkbox"/> NO	DATE GRADUATED	TYPE OF DEGREE RECEIVED
NAME OF SCHOOL	SCHOOL LOCATION		ENROLLMENT DATES FROM: _____ TO: _____	WILL HLO BE RECEIVING A TRANSCRIPT FROM THIS SCHOOL? <input type="checkbox"/> YES <input type="checkbox"/> NO
COURSE OF STUDY	SEMESTER/QUARTER HOURS EARNED	DEGREE EARNED? <input type="checkbox"/> YES <input type="checkbox"/> NO	DATE GRADUATED	TYPE OF DEGREE RECEIVED
NAME OF SCHOOL	SCHOOL LOCATION		ENROLLMENT DATES FROM: _____ TO: _____	WILL HLO BE RECEIVING A TRANSCRIPT FROM THIS SCHOOL? <input type="checkbox"/> YES <input type="checkbox"/> NO
COURSE OF STUDY	SEMESTER/QUARTER HOURS EARNED	DEGREE EARNED? <input type="checkbox"/> YES <input type="checkbox"/> NO	DATE GRADUATED	TYPE OF DEGREE RECEIVED

Please ensure that all areas of this form are filled in and return this completed form with your application. Remember to retain a copy for your records.

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COURSE CONTENT COMPARISON

IMPORTANT: To ensure that you receive credit for courses you have taken you must complete each line of this form, identifying each course title, credits received, educational institution providing credit, and completion date for each of the educational areas listed on this form, and you must submit this completed form with your application.

APPLICANT NAME: LAST FIRST MIDDLE INITIAL

Educational Areas	Credits Required	Title of Comparable Course(s)	Credits Received	Educational Institution Providing Credit	Completion Date(s)
Orofacial Anatomy	2				
Dental Histology and Embryology	2				
Pharmacology	3				
Emergency Care or Medical Emergencies	1				
Oral Pathology	3				
Pathology Emphasizing Periodontology	2				
Dental Materials	5				
Professional Ethics and Jurisprudence	1				
Geriatrics	2				
Microbiology and Infection Control	4				
Clinical Denture Technology	16				
Laboratory Denture Technology	37				
Nutrition	4				
General Anatomy and Physiology	8				
General Education and Electives	13				

Please ensure that all areas of this form are filled in and return this completed form with your application. Remember to retain a copy for your records.

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***CERTIFICATION OF SUPERVISED CLINICAL PRACTICE
 WORK EXPERIENCE AND TRAINING (PATHWAY TWO)***

This form must be completed and signed by both the individual applicant receiving the 1,000 hours of supervised clinical practice work experience and the employing/supervising denturist or dentist.

1. Applicant Information

APPLICANT NAME: LAST		FIRST	MI
TRAINING START DATE		TRAINING END DATE	
ADDRESS WHERE TRAINING WAS RECEIVED			
CITY		STATE	ZIP
AVERAGE HOURS WORKED PER WEEK:	TOTAL NUMBER OF SUPERVISED CLINICAL PRACTICE HOURS PROVIDED:	TOTAL NUMBER OF DENTURE UNITS CONSTRUCTED AND FITTED:	

1,000 Hours Of Supervised Clinical Practice Must Include A Minimum Of:

- **Clinical:** 400 hours in direct patient care in denture technology; **and**
- **Laboratory:** Construction of a minimum of 40 removable dentures, on 40 different patients. *Each removable denture will be counted as one denture; an upper and a lower removable denture counts as two removable dentures.*

While employed under my supervision, the applicant was trained in, and performed the following procedures (*specify actual clock hours completed for each procedure*):

LABORATORY	HOURS	CLINICAL	HOURS
Constructing	_____	Impressions	_____
Repairing	_____	Bite registration	_____
Relining	_____	Try-ins / insertions	_____
		Reproducing / duplicating	_____
		Fitting / altering	_____
Total Hours	_____	Total Hours	_____

2. Supervising Denturist/Dentist

NAME: LAST		FIRST	MIDDLE INITIAL
BUSINESS ADDRESS			
CITY		STATE	ZIP
LICENSE NO.	DENTURIST <input type="checkbox"/>	DENTIST <input type="checkbox"/>	LICENSE EXPIRATION DATE
PHONE: BUSINESS	CELL	EMAIL ADDRESS	

I certify that the above information is true and correct to the best of my knowledge.

➤ Denturist/Dentist Signature: _____ Date: _____

➤ Applicant Signature: _____ Date: _____