



**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](http://healthoregon.org/hlo) | Email: [hlo.info@state.or.us](mailto:hlo.info@state.or.us)

**DENTURIST TEMPORARY LICENSE 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:
State:	Lic./Cert./Reg.#	Expiration:
State:	Lic./Cert./Reg.#	Expiration:

**2. SUPERVISOR INFORMATION**

SUPERVISOR NAME: LAST FIRST MIDDLE INITIAL

Supervisor is licensed as a:  Denturist  Dentist

License # \_\_\_\_\_ Expiration Date: \_\_\_\_\_

**3. \*\*\* (Complete This Section Only If Submitting Payment By Mail) \*\*\***

**Method Of Payment For Application Fee = \$50: License Fee = \$50**

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: \_\_\_\_\_

(Do not write in this section – Official use only)

License #: \_\_\_\_\_ Initials \_\_\_\_\_ OTC  Verified ID  Type: \_\_\_\_\_

**4. 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**):

● Have you ever been convicted of a misdemeanor or felony?  **Yes**  **No**  
 If yes, please list **all** convictions, including the charges as stated in the court documents and year convicted (**attach additional pages if necessary**).

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:**

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:**

## 5. Affirmative Action – Voluntary Question (Applicant)

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 TEMPORARY 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 = **\$50**; **and** payment of the required temporary license fees = **\$50** *(see method of payment section above)*;
- Submit one form of acceptable **photographic** identification as outlined in OAR 331-030-0000(10), **which must include applicant's current legal name:** Front and back of legible (clear) photocopies if submitted by mail; *driver license, state ID card, passport or military ID card*; and
- Provide documentation of completing a qualifying pathway *(See qualifying pathways below)*.

**Return All Pages Of This Application And Keep A Copy For Your Records**

**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 written examination within two years before the date of application; and
- Submit supervisor information on a form prescribed by the HLO.

**(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 pursuant to OAR 331-410-0012 on a form prescribed by the HLO (*see Clinical Work Experience Training form below*);
- Have completed and passed a Board approved written examination within two years before the date of application; and
- Submit supervisor information on a form prescribed by the HLO.



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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*):

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

**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.***

<b>➤ Denturist/Dentist Signature:</b>	<b>Date:</b>
<b>➤ Applicant Signature:</b>	<b>Date:</b>