

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 with or 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.

Perform Interim Therapeutic Restorations after diagnosis by a dentist. *Verification of completion of a Board approved ITR course must be sent to the OBD directly from the program.

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, drafted and 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: _____