Oregon
Tina Kotek, Governor

Board of Dentistry
1500 SW 1st Ave, Ste 770
Portland, OR 97201-5837
(971) 673-3200

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 an Expanded Practice Dental Hygienist after obtaining a permit from the Board. Please review ORS 680.200 and ORS 680.205, and OAR 818-035-0065 and OAR 818-035-0066 for the statutes and rules related to the Expanded Practice Permit.

INSTRUCTIONS - PATHWAY I

To obtain an Expanded Practice Permit, you must print and mail this application along with the required fee to the following address:

Oregon Board of Dentistry
Unit 23
PO Box 4395
Portland, OR 97208

The following must be submitted with this application:

1. **Permit Fee - $75.00:** Must be in the form of a personal check, cashier's check or money order made payable to the Oregon Board of Dentistry. Your fee must be enclosed in the same envelope with your application, and mailed to the address indicated above.

2. **Healthcare Provider Basic Life Support (BLS) Certification:** Enclose documentation showing that you hold a valid and current Health Care Provider BLS certification.

3. **Proof of Professional Liability Coverage:** Submit documentation of current professional liability insurance coverage (either your own policy, or your employer's. Please note that if using your employer's policy, you will not be permitted to use your EPP anywhere other than the clinic under which you are insured).

4. **Certification of Clinical Practice Form:** List all dentists and locations at which you practiced dental hygiene to verify the 2,500 hours of licensed clinical practice.

5. **Certification of CE Form:** Applicants must complete 40 hours of CE related to clinical dental hygiene and/or dental public health. ***CE must be sponsored by Board-approved CE providers - see enclosed list.***

OPTIONAL:

Collaborative Agreement (Page 4 of application): 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 drafted and signed by both parties, attached to the Verification of Collaborative Agreement form (also signed by both parties) which is included in this packet, and submitted to the Board.

a. Administering local anesthesia;
b. Administering temporary restorations with or without excavation;
c. Prescribing prophylactic antibiotics and nonsteroidal anti-inflammatory drugs specified in the agreement;
d. Performing interim therapeutic restorations after diagnosis by a dentist; and
e. Referral parameters.

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

If you have questions, please email Information@obd.oregon.gov or call (971) 673-3200

DENTAL HYGIENE EXPANDED PRACTICE PERMIT (PATHWAY 1): OREGON BOARD OF DENTISTRY-APPROVED CONTINUING EDUCATION PROVIDERS

ADVANTAGE DENTAL PLAN INC.
CE Coordinator: Kimberly Krueger
442 SW Umatilla Ave.
Redmond, OR 97756
(866) 268-9616
www.advantagedental.com
Curriculum Approved: August 3, 2012

AMERICAN DENTAL HYGIENISTS' ASSOCIATION
CE Coordinator: Cathy Elliott, RDH, BSDH
4444 N. Michigan Ave., Ste. #3400
Chicago, IL 60611
(312) 440-8900
education@adha.net
www.adha.org
Curriculum Approved: June 1, 2012

EXCEPTIONAL NEEDS DENTAL SERVICES
CE Coordinator: Tonia Ayres
12029 NE Sumner St.
Portland, OR 97220
(503) 295-1201
Curriculum Approved: February 29, 2017

HYGIENE A.D.E. STUDY CLUB
8623 SW 19th Ave.
Portland, OR 97219
(503) 351-6060
hygieneadestudyclub@gmail.com
Curriculum Approved: June 21, 2013

LANE COUNTY DENTAL HYGIENIST'S ASSOCIATION
PO Box 544
Creswell, OR 97426
(541) 968-3874
LaneCountyDHA@gmail.com
Curriculum Approved: December 19, 2014

MARION COUNTY DENTAL HYGIENE STUDY CLUB
CE Coordinator: Laurie Goodspeed
1433 Yakima Court NW
Salem, OR 97304
(503) 302-7748
www.mcdhstudyclub.org
Curriculum Approved: December 13, 2019

OREGON DENTAL ASSOCIATION
PO Box 3710
Wilsonville, OR 97070
(503) 218-2010
www.oregondental.org
info@oregondental.org
Curriculum Approved: February 10, 2012

OREGON DENTAL HYGIENISTS' ASSOCIATION
147 SE 102nd Ave.
Portland, OR 97216
(503) 595-0220
info@odha.org
www.odha.org
Curriculum Approved: April 6, 2012

OREGON HEALTH & SCIENCE UNIVERSITY SCHOOL OF DENTISTRY CONTINUING EDUCATION PROGRAM
CE Coordinator: Alexandria Case
2730 SW Moody Ave.
Portland, OR 97201
(503) 494-8857
www.ohsu.edu
cdeinfo@ohsu.edu
Curriculum Approved: February 15, 2019

OREGON HEALTH AUTHORITY
800 NE Oregon St., Ste. #825
Portland, OR 97232
(971) 673-0348
laurie.johnson@dhsohs.state.or.us
Curriculum Approved: June 21, 2013

OREGON ORAL HEALTH COALITION
PO Box 3132
Wilsonville, OR 97070
(971) 224-1038
Philip.Giles@OCDC.net
Curriculum Approved: April 19, 2013

OREGON INSTITUTE OF TECHNOLOGY
3201 Campus Drive
Klamath Falls, OR 97601
(541) 885-1277
Paula.Russell@oit.edu
www.oit.edu
Curriculum Approved: February 28, 2014

PACIFIC UNIVERSITY CONTINUING EDUCATION DEPARTMENT
222 SE 8th Ave., Suite #573
Hillsboro, OR 97123
(503) 352-2663
Pacific University CE Website
lisa.downing@pacificu.edu
Curriculum Approved: April 19, 2013

PACIFIC UNIVERSITY SCHOOL OF DENTAL HYGIENE STUDIES
222 SE 8th Ave., Suite #272
Hillsboro, OR 97123
(503) 352-2673
Pacific University School of DHS Website
kihei@pacificu.edu
Curriculum Approved: February 23, 2018

PORTLAND COMMUNITY COLLEGE DENTAL HYGIENE STUDY CLUB
CE Coordinator: Marissa Turner
17905 SW Vincent St.
Aloha, OR 97078
(559) 824-7350
marissadturner@gmail.com
PCCDHSC@gmail.com
Curriculum Approved: February 15, 2013

PROFESSIONAL THERAPIES NORTHWEST
CE Coordinator: Debbie Howard
12068 Lakeside Place NE
Seattle, WA 98125
(888) 365-1760
www.professionaltherapiesnw.com
course@professionaltherapiesnw.com
Curriculum Approved: October 13, 2017

THE PROCTOR & GAMBLE COMPANY
CE Coordinator: Nancy Richter
8700 Mason-Montgomery Road, CF3-6B5
Mason, OH 45040
(513) 622-0099
www.dentalcare.com
Curriculum Approved: June 1, 2012

WILLAMETTE DENTAL GROUP
CE Coordinator: Kristin Barton
6950 NE Campus Way
Hillsboro, OR 97124
1-855-4DENTAL x810507
www.willamettedental.com
Curriculum Approved: February 15, 2019

PLEASE NOTE THAT ALL CE COURSES FOR THE EPP PATHWAY 1 APPLICATION MUST BE SPONSORED BY ONE OF THE APPROVED PROVIDERS LISTED ABOVE, AND DIRECTLY RELATED TO CLINICAL DENTAL HYGIENE AND/OR DENTAL PUBLIC HEALTH.

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

Rev. Code 2142

APPLICATION FOR DENTAL HYGIENE EXPANDED PRACTICE PERMIT
PATHWAY 1
DENTAL HYGIENIST
FEE $75.00

Name _____ License No. _____

Mailing Address _____

City _____ State _____ Zip _____

Email _____

The following must be submitted with this application:

1. Permit Fee - $75.00: Must be in the form of a personal check, cashier's check or money order made payable to the Oregon Board of Dentistry. Your fee must be enclosed in the same envelope with your application, and mailed to the address indicated above.

2. Healthcare Provider Basic Life Support (BLS) Certification: Enclose documentation showing that you hold a valid and current Health Care Provider BLS certification.

3. Proof of Professional Liability Coverage: Submit documentation of current professional liability insurance coverage (either your own policy, or your employer's. Please note that if using your employer's policy, you will not be permitted to use your EPP anywhere other than the clinic under which you are insured).

4. Certification of Clinical Practice Form: List all dentists and locations at which you practiced dental hygiene to verify the 2,500 hours of licensed clinical practice.

5. Certification of CE Form: Applicants must complete 40 hours of CE related to clinical dental hygiene and/or dental public health. CE must be sponsored by Board-approved CE providers - see enclosed list.

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 _____

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 persons with mental illness, as defined in ORS 426.005;

☐ (G) Facilities for persons with developmental disabilities, as 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: _____

EXPANDED PRACTICE PERMIT
CERTIFICATION OF CLINICAL PRACTICE

List all locations at which you practiced to verify the 2,500 hours of supervised licensed clinical dental hygiene practice pursuant to ORS 680.200(A)(I). Use additional sheets if necessary.

Supervising Dentist Name: ______________________________ **Telephone Number:** _____________

Location/Address: ____
Address City State Zip Code

Average hours per week __________________ _____ **years** _____**months**

From _______________________ to ___________________ **TOTAL HOURS WORKED**__________
Date Date

Supervising Dentist Name: ______________________________ **Telephone Number:** _____________

Location/Address: ____
Address City State Zip Code

Average hours per week __________________ _____ **years** _____**months**

From _______________________ to ___________________ **TOTAL HOURS WORKED**__________
Date Date

Supervising Dentist Name: ______________________________ **Telephone Number:** _____________

Location/Address: ____
Address City State Zip Code

Average hours per week __________________ _____ **years** _____**months**

From _______________________ to ___________________ **TOTAL HOURS WORKED**__________
Date Date

Supervising Dentist Name: ______________________________ **Telephone Number:** _____________

Location/Address: ____
Address City State Zip Code

Average hours per week __________________ _____ **years** _____**months**

From _______________________ to ___________________ **TOTAL HOURS WORKED**__________
Date Date

Supervising Dentist Name: ______________________________ **Telephone Number:** _____________

Location/Address: ____
Address City State Zip Code

Average hours per week __________________ _____ **years** _____**months**

From _______________________ to ___________________ **TOTAL HOURS WORKED**__________
Date Date

By signing below I certify that I have completed at least 2,500 hours of supervised licensed clinical dental hygiene practice. 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: __________________

CERTIFICATION OF CONTINUING EDUCATION (CE) FORM

List 40 hours of CE related to direct clinical patient care or the practice of dental public health. CE may be taken anytime during your career as an Oregon licensed Dental Hygienist. ***CE must be completed through a board-approved CE provider. See enclosed list.*** (You may attach additional sheets as necessary)

COURSE TITLE/BRIEF DESCRIPTION	BOARD APPROVED CE PROVIDER	HOURS

I have successfully completed 40 hours of CE courses sponsored by continuing education providers that have been approved by the Board and related to clinical dental hygiene or dental public health. By signing below, I certify that the information given on this form is true and correct. I understand that any falsification could result in denial of my application.

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 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: _____