



# Oregon

John A. Kitzhaber, MD, Governor

Board of Dentistry  
1600 SW 4<sup>th</sup> Avenue  
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[www.oregon.gov/dentistry](http://www.oregon.gov/dentistry)

## **Expanded Practice Dental Hygiene CE Provider Application Instructions**

1. **Provider Name:** List the full business name or individual's name.
2. **Business Phone No.:** List the business phone number. This phone number will be placed on the Board's Web site.
3. **Mailing Address:** List the mailing address. This address is public record and will be placed on the Board's Web site.
4. **Organization Type:** List the primary organization type of provider.
5. **CE Coordinator's Name:** List the name of the individual who will be responsible for administering the Provider's CE program. This person will be the primary contact for the Oregon Board of Dentistry.
6. **CE Coordinator's Phone No.:** List CE Coordinator's phone number if different from business phone number.
7. **Instructor's Education/Training:** Each instructor must attach a resume or curriculum vitae (CV). If you are not an individual, but an entity, please submit a listing of your most recent catalog of courses.

Return the completed application along with instructor's resume/curriculum vitae to the Oregon Board of Dentistry, 1600 SW 4<sup>th</sup> Avenue, Suite 770, Portland, Oregon 97201.

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

Board Approved:

**Oregon Board of Dentistry**  
**1600 SW 4<sup>th</sup> Avenue, Suite 770**  
**Portland, OR 97201**  
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**(971) 673-3200**

**Expanded Practice Dental Hygiene  
Continuing Education (CE) Provider Application**

Provider Name (name of individual or facility):		Business Phone No.:
Mailing Address ( <i>street address, city, state, zip</i> ):		
Email or Web site (optional):	Taxpayer ID Number:	Will Offer On-line Courses: <input type="checkbox"/> No <input type="checkbox"/> Yes
Organization Type (select one): <input type="checkbox"/> Association <input type="checkbox"/> 2 or 4 yr Institution of Higher Learning <input type="checkbox"/> Non-Profit Corporation <input type="checkbox"/> Licensed Health Facility <input type="checkbox"/> Other education organization Individual <input type="checkbox"/> Government Agency <input type="checkbox"/> Corporation <input type="checkbox"/> Other (please specify):		
CE Coordinator Name:		CE Coordinator Phone No.:
Instructor's Education/Training (attach Instructor(s) resume or curriculum vitae (CV)):		
CE Coordinator's Signature:		Date: