Oregon Health Authority

HEALTH LICENSING OFFICE
**Board of Denture Technology**

1430 Tandem Ave. NE, Suite 180, Salem, OR 97301-2192
Phone: (503) 378-8667 | Web: www.oregon.gov/oha/ph/hlo

Print Form

| For Office Use Only | | |
|---|---|---|
| Applicant #: | License #: | Staff Initials: |

# *Denturist Temporary License Application*

## Applicant Information

| | | | | |
|---|---|---|---|---|
| LAST NAME: | FIRST NAME: | | | MIDDLE INITIAL: |
| BIRTHDATE: | GENDER: | ☐ FEMALE | ☐ MALE | ☐ NONBINARY / OTHER |
| RESIDENTIAL PHYSICAL ADDRESS (**REQUIRED**): | | | | |
| CITY: | STATE: | | | ZIP: |
| MAILING ADDRESS (IF DIFFERENT FROM ABOVE): | | | | |
| CITY: | STATE: | | | ZIP: |
| BUSINESS PHONE: | PERSONAL PHONE: | | | |
| EMAIL (**REQUIRED**): | SOCIAL SECURITY # (**REQUIRED**): | | | |

Have you ever been known under any other legal name? ☐ **No** ☐ **Yes** If yes, list all previous full (legal) names below:

Previous legal 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 (add additional blank page if necessary):

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

## Payment Information (complete this section only if submitting payment by mail)

**Required Fees:** *The application fee is non-refundable. **DO NOT MAIL CASH.**

| ***Application Fee = $50** | **Temporary License Fee = $50** | **Total of $100** |
|---|---|---|

| Select one payment option: | ☐ Check | ☐ Credit Card (see below) | ☐ Money Order | ☐ Purchase Order |
|---|---|---|---|---|
| Type of credit card (American Express card is not accepted): | ☐ Visa | ☐ Mastercard | ☐ Discover | |

**Note:** The credit card holder must either be the applicant or be present at the time this application is submitted.

Name on credit card:

| Card number: | Exp date: | Authorized amount: $ |
|---|---|---|

Cardholder signature:

**(Do not write in the following section – Office use only)**

☐ **OTC** ☐ **Verified ID** ☐ **Verified Out-of-state Licensure Type of ID:** _____ **Appr Code/CK #** _____ **Staff Initials** _____

| | | |
|---|---|---|
| Payment method: ☐ Cash ☐ Check ☐ MO ☐ PO<br>☐ Visa ☐ MasterCard ☐ Discover<br>AMOUNT: _____<br>INITIALS: _____<br>☐ Approval code/CK#: _____ | Payment method: ☐ Cash ☐ Check ☐ MO ☐ PO<br>☐ Visa ☐ MasterCard ☐ Discover<br>AMOUNT: _____<br>INITIALS: _____<br>☐ Approval code/CK#: _____ | Payment method: ☐ Cash ☐ Check ☐ MO ☐ PO<br>☐ Visa ☐ MasterCard ☐ Discover<br>AMOUNT: _____<br>INITIALS: _____<br>☐ Approval code/CK#: _____ |
| | | |

## Individual Records Questions

Please accurately answer all the questions below. The Health Licensing Office (HLO) 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.

1. Do you have any pending or completed investigations or any disciplinary actions taken against you by any licensing or regulatory authority? 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, attach an additional page(s) and provide an explanation.

| 2. Have you ever been convicted of a misdemeanor or felony? ☐ **Yes** ☐ **No** If yes, please list all convictions, including the charges and year convicted (attach additional pages if necessary). | **Year Convicted** |
|---|---|
| | |
| | |

3. 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.

## Mandatory Social Security Number Disclosure and Use

You are required to provide your Social Security number (SSN) to the HLO as part of your application for initial or renewed occupational or professional license, certification, or registration issued by HLO pursuant to ORS 25.785, ORS 305.385, 42 USC § 666(a)(13) and 42 USC §405(c)(2)(C)(i). Failure to provide your SSN will be a basis to refuse to issue or renew the license, certification, or registration you seek. HLO is authorized by law to use your SSN for child support enforcement and tax administration purposes only. HLO will only use your SSN for these purposes unless you authorize other uses of your SSN as discussed below. Your SSN will remain on file with HLO. If you have never been assigned an SSN, please refer to the section below titled Request for Exemption from Social Security Number Disclosure and Attestation.

## Voluntary SSN Disclosure and Use - Criminal Background Checks and Military Status Verification

The HLO is authorized to conduct criminal background checks pursuant to ORS 181A.195, 676.608, and 676.612. The HLO requests that you voluntarily provide your SSN for this purpose. Pursuant to 50 USC § 3931, the HLO must determine the military status (or lack thereof) of a respondent before issuing a default final order. The HLO requests that you voluntarily provide your SSN for this purpose. Failure to provide your SSN for these purposes will not be used to deny your application, or to deny you any right, benefit or privilege provided by law. If you consent to the use of your SSN by the HLO for these purposes, it may be used only for these purposes.

4. I voluntarily consent to disclose my SSN to the HLO for criminal background checks and military status verification.
   ☐ **Yes** ☐ **No**

## Voluntary Social Security Number Disclosure and Use – Reporting to the National Practitioner Data Bank (NPDB)

For any HLO license, certification, or registration that reports to the National Practitioner Data Bank (NPDB), if any disciplinary action is taken against you, HLO requests that you voluntarily provide your SSN so that HLO may report it to the NPDB under Title IV of Public Law 99-660, the Health Care Quality Improvement Act of 1986; Section 1921 of the Social Security Act; Section 1128E of the Social Security Act; and their implementing regulations found at 45 CFR Part 60. Failure to provide your SSN for this purpose will not be used to deny your application, or to deny you any right, benefit or privilege provided by law. If you consent to the use of your SSN by the HLO for this purpose, it may be used only for this purpose.

5. I voluntarily consent to disclose my SSN to the HLO to report to the NPDB. ☐ **Yes** ☐ **No**

## Request for Exemption from Social Security Number Disclosure and Attestation

6. If you do not have a Social Security number (SSN) you may request an exemption from the SSN requirement. To receive the exemption, you must attest and certify that you have never been assigned an SSN and if you are ever assigned an SSN, you will report it to the HLO within 30 days.

   ***DO NOT SIGN BELOW IF YOU HAVE A SOCIAL SECURITY NUMBER***

   By signing below, I attest and certify that I have never been assigned an SSN and agree that if an SSN is assigned to me, I will report it to the HLO within 30 days.

| Applicant Signature: | Date: |
|---|---|

## Certification of Information Provided

7. I have examined this application and supporting documentation and certify by my signature below that it is true, correct, and complete. I understand that providing false information or 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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## Affirmative Action – Voluntary Question

The State of Oregon has an Affirmative Action (AA) Policy. If you choose to provide the optional information below, it will help to evaluate the effectiveness of our AA 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.

**Which of the following describes your racial or ethnic identity?** Please check all that apply.

**American Indian and Alaska Native**

_____ American Indian
_____ Alaska Native
_____ Canadian Inuit / Metis / First Nation
_____ Indigenous Mexican / Central American / South America

**Asian**

_____ Asian Indian
_____ Cambodian
_____ Chinese
_____ Communities of Myanmar
_____ Filipino / Filipina
_____ Hmong
_____ Japanese
_____ Korean
_____ Laotian
_____ South Asian
_____ Vietnamese
_____ Other Asian

**Black and African American**

_____ African American
_____ Afro-Caribbean
_____ Ethiopian
_____ Somali
_____ Other African (Black)
_____ Other Black

**Hispanic and Latino/Latina/Latinx**

_____ Central American
_____ Mexican
_____ South American
_____ Other Hispanic or Latino/Latina/Latinx

**Middle Eastern / North African**

_____ Middle Eastern
_____ North African

**Native Hawaiian and Pacific Islander**

_____ Chamoru/Chamorro
_____ Guamanian
_____ Marshallese / Micronesian / Palauan / Tongan
_____ Communities of the Micronesian Region
_____ Native Hawaiian
_____ Samoan
_____ Other Pacific Islander

**White**

_____ Eastern European
_____ Slavic
_____ Western European
_____ Other White

**Other Categories**

_____ Other: _____
_____ Unknown
_____ Decline to answer

If you checked more than one race or ethnicity above, is there **one** you think of as your primary racial or ethnic identity?

_____ Yes, please list: _____
_____ I do not have just one primary racial or ethnic identity
_____ No, I identify as Bi-racial or Multi-racial
_____ Not applicable, I only checked one category above
_____ Unknown
_____ Decline to answer

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# Denturist Temporary License Information

**Note: Any reference to the term "license" on this application means a temporary license issued by the Health Licensing Office.**

Temporary license holders:

- A denture technology temporary license authorizes the holder to temporarily practice denture technology while waiting to take a Board-approved practical examination including qualifying to retake examinations.
- A denture technology temporary license is valid for one year and may be renewed one time.
- A denture technology temporary license holder may work under indirect supervision. Indirect supervision means the supervisor is available by phone or by other means of electronic communication. The supervisor must be able to reasonably oversee the work of the individual being supervised and be available for questions and assistance when needed.
- A denture technology temporary license holder must notify the Health Licensing Office within 10 calendar days of changes in employment status or changes in supervisor status.
- A denture technology temporary license is invalid after passage of the written and practical examinations.
- A denture technology temporary license holder who changes supervisors more than three times must receive approval from the Board prior to making a fourth or subsequent change.
- A denture technology temporary license holder must adhere to all practice standards listed in the Board of Denture Technology Oregon Administrative Rules.
- A denture technology temporary license holder may not reapply for additional temporary licenses.

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# Application Requirements

**PLEASE NOTE:** The applicant is responsible for payment of fees assessed by the issuing organization(s) when obtaining required official documentation.

## Applicant must:

| | |
|---|---|
| ——— | Meet the requirements of Oregon Administrative Rule, Chapter 331, Division 30. |
| ——— | Submit this completed application, accompanied by payment of the required fees.<br>*Application fee = **$50**; and Temporary License fee = **$50**; for a total of **$100** (see payment information on first page).<br>***THE APPLICATION FEE IS NON-REFUNDABLE.***<br>***DO NOT SEND CASH THROUGH THE MAIL.*** |
| ——— | Submit **one** form of original identification issued by a government agency. Acceptable identification options can be found under Chapter 331, Division 30 of Oregon Administrative Rule.<br>**ID requirements are as follows:**<br>• The ID must be issued by a government agency.<br>• The ID must include the applicant's current legal name.<br>• The ID provided must be photographic.<br>• We do not accept student ID cards, department store or warehouse cards, debit cards, etc. If you have a question about whether a particular ID type is acceptable, please call (503) 378-8667, to verify.<br>• If submitting a photocopy of your ID by mail, a legible (clear) front and back copy must be submitted. Submit the copy on a full-sized piece(s) of copy paper, do not cut the ID images out.<br>If you do not meet all of the ID requirements above, you run the risk of your application process being delayed. |
| ——— | Provide documentation of completing one of the following qualifying pathways (see qualifying pathway options on the following page). |

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## Pathway Options

| | |
|---|---|
| **Pathway One: Qualification through an associate degree program or equivalent education with 1,000 hours supervised clinical practice in denture technology within an educational program.** | |
| ——— | Submit official transcript demonstrating completion of a Health Licensing Office approved associate degree program in denture technology or equivalent education. The official transcript must document completion of 1,000 hours supervised clinical practice. |
| ——— | Complete and pass a Board approved ***written examination*** within two years of the date of this application. The scores must be submitted by the testing service directly to the Health Licensing Office including passed and failed examination scores. Proof must be issued or mailed directly to the Health Licensing Office from the certifying organization. Examination results or other documentation provided directly by the applicant are not acceptable. |
| ——— | Submit supervisor information under the "Supervisor Information" section on the last page of this application. |
| **Note:** An applicant is not required to provide an 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 this application. | |
| **Pathway Two: Qualification through an associate degree program or equivalent education with 1,000 hours supervised clinical practice in denture technology under an approved supervisor.** | |
| ——— | Submit official transcript demonstrating completion of a Health Licensing Office approved associate degree program in denture technology or equivalent education. |
| ——— | Submit documentation of 1,0000 hours of supervised clinical practice under an approved supervisor on a form prescribed by the Health Licensing Office. |
| ——— | Complete and pass a Board approved ***written examination*** within two years of the date of this application. The scores must be submitted by the testing service directly to the Health Licensing Office including passed and failed examination scores. Proof must be issued or mailed directly to the Health Licensing Office from the certifying organization. Examination results or other documentation provided directly by the applicant are not acceptable. |
| ——— | Submit supervisor information under the "Supervisor Information" section on the last page of this application. |
| **Note:** An applicant is not required to provide an official transcript, documentation of 1,000 hours of 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 this application for a full denture technology license. | |

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## Course Content Comparison

**Note:** To ensure that you receive credit for courses you have taken, you must complete each line of this form to identify each course title, credits received, educational institution providing credit, and completion date for each of the educational areas listed on this form. Submit this form with the application.

| LAST NAME: | FIRST NAME: | MIDDLE INITIAL: |
|---|---|---|

| Educational Areas | Credits Required | Title of Comparable Course(s) | Credits Received | Educational Institution Providing Credit | Completion Dates(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** | | | | |

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# *Certification of Supervised Clinical Practice Work Experience and Training (Pathway Two)*

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

## Applicant Information

| LAST NAME: | FIRST NAME: | MIDDLE INITIAL: |
|---|---|---|
| ADDRESS WHERE TRAINING WAS RECEIVED: | | |
| CITY: | STATE: | ZIP: |

## Supervisor / Employer Information

| LAST NAME: | FIRST NAME: | MIDDLE INITIAL: |
|---|---|---|
| EMPLOYER / BUSINESS NAME: | | |
| EMPLOYER / BUSINESS WORK ADDRESS: | | |
| CITY: | STATE: | ZIP: |
| SUPERVISOR PHONE NUMBER: | SUPERVISOR EMAIL: | |

## Supervised Clinical Practice Work Experience Information

| TRAINING START DATE: | TRAINING END DATE: |
|---|---|
| AVERAGE HOURS WORKED PER WEEK: | |

**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.

| |
|---|
| TOTAL NUMBER OF SUPERVISED CLINICAL PRACTICE HOURS PROVIDED: |
| TOTAL NUMBER OF DENTURE UNITS CONSTRUCTED AND FITTED: |

## Training and Procedures

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 |
|---|---|
| Constructing | |
| Repairing | |
| Relining | |
| **Total Hours:** | |

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# *Certification of Supervised Clinical Practice Work Experience and Training (Pathway Two)*

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

## Training and Procedures (continued)

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

| Clinical | Hours |
|---|---|
| Impressions | |
| Bite registration | |
| Try-ins / insertions | |
| Reproducing / duplicating | |
| Fitting / altering | |
| **Total Hours:** | |

## Supervising Denturist / Dentist

| | | |
|---|---|---|
| LAST NAME: | FIRST NAME: | MIDDLE INITIAL: |
| EMPLOYER / BUSINESS NAME: | | |
| EMPLOYER / BUSINESS WORK ADDRESS: | | |
| CITY: | STATE: | ZIP: |
| ☐ DENTURIST ☐ DENTIST | LICENSE #: | LICENSE EXP. DATE: |
| SUPERVISOR PHONE NUMBER: | SUPERVISOR EMAIL: | |

**By my signature below**, I certify the named applicant has received 1,000 hours of supervised clinical practice work experience, and the information provided is true and correct.

| | |
|---|---|
| Signature: | Date: |

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# Application Requirements (continued)

**PLEASE NOTE:** The applicant is responsible for payment of fees assessed by the issuing organization(s) when obtaining required official documentation.

| **Applicant must:** | |
|---|---|
| ——— | Have you answered questions 1 through 5 on page two of this application? If you fail to answer each of the questions, this application may be returned to you and potentially cause a delay in processing. |
| ——— | If you do not have a social security number (SSN), have you signed and dated section 6 on page two of this application? If you do have an SSN that you have provided on page one, do not complete this section. |
| ——— | Have you signed and dated section 7 on page two of this application? If you fail to sign and date this section, your application will be returned to you and will cause a delay in processing. |
| ——— | Have you completed the payment information section of this application and enclosed payment or provided credit card information? |
| ——— | Keep a copy of your application and supporting documents before submitting everything to the Health Licensing Office (HLO).<br>You have two options to submit your application (**submit your application only once**):<br>1. Mail the application. Enclose payment or provide credit card information, enclose copies of your identification, and enclose copies of your required supporting documents to the HLO. The address is listed at the top of this application.<br>2. Bring the application to the HLO. Bring the completed application, payment for fees, two forms of your original identification, and required supporting documents to the HLO. The address is listed at the top of this application. |