

**Maryland State Board of Dental Examiners  
Spring Grove Hospital Center • Benjamin Rush Building  
55 Wade Avenue  
Catonsville, Maryland 21228  
(410) 402-8510**

**APPLICATION FOR  
RECOGNITION TO ADMINISTER LOCAL ANESTHESIA BY INFILTRATION**

**USE THIS FORM IF YOU SEEK RECOGNITION TO ADMINISTER LOCAL ANESTHESIA BY  
INFILTRATION BY VIRTUE OF CERTIFICATION OR OTHER RECOGNITION IN ANOTHER STATE.  
THERE IS ANOTHER FORM FOR THOSE WHO ARE NOT RECOGNIZED IN ANOTHER STATE.**

**GENERAL INSTRUCTIONS**

Complete all portions of the application. Enclose a \$50 (dollar) non-refundable check or money order made payable to the Maryland State Board of Dental Examiners. Enclose all necessary documents. Failure to do so may result in the return of the application.

**Notice For Mailing List:**

The information collected on this application form is collected for the purposes of the Board's functions under the Annotated Code of MD, Health Occupations Article, Title 4. Failure to provide the information may result in denial of your application. You have a right to inspect, amend, and request correction of this information. The Board may permit inspection of this information or make it available to others only as permitted by federal and State law. Under the Maryland Public Information Act, Annotated Code of Maryland, General Provisions Article, §4-333, the Board may provide, for a fee, a list of licensees' names and addresses to professional associations and other entities. You may request in writing that your name be omitted from such lists.

**SECTION I – GENERAL INFORMATION**

<b>Name (Last, First, Middle Initial):</b>	
<b>Address of Record: (Street Address)</b>	
<b>City, State, Zip:</b>	
<b>Dental Hygiene License Number:</b>	

**Note: If the address you have provided to the Board in this application differs from the address you have on file with the Board you must file a change of address form with the Board. The Board will not change the address it has on file if the address on this form differs from the address it already has on file. Failure to do so may result in your not receiving important information from the Board and may ultimately result in disciplinary action. Please keep an updated address on file with the Board at all times.**

**A. Social Security Number:**       -   -

(There is a statutory requirement that you disclose your social security number. It will be used for identification purposes only.)

**B. Date of Birth:**                      -   -

**C. Home Phone Number:**           -    -

**D. Work Phone Number:**           -    -

**E. E-Mail Address:**

**F. Licensure in other states:**

List other states or jurisdictions in which you hold or have held a dental hygiene license.

State	License Number	Expiration Date

**G. Certification in other states:**

List other states or jurisdictions in which you hold or have held a certificate to administer local anesthesia.

State	Certificate Number	Expiration Date

**SECTION II - EDUCATION**

**A. School of Dental Hygiene (Name, City, State, Country):** \_\_\_\_\_

\_\_\_\_\_

**B. Date of Graduation:** \_\_\_\_\_ **Degree Earned:** \_\_\_\_\_

**SECTION III – RECOGNITION TO ADMINISTER LOCAL ANESTHESIA BY INFILTRATION**

A. What current state certification in local anesthesia by infiltration are you using as a basis for certification in Maryland.

Name of state: \_\_\_\_\_

Date certification was issued: \_\_\_\_\_

Date of expiration: \_\_\_\_\_

B. Have you passed the North East Regional Board Local Anesthesia Examination for Dental Hygienists?

Yes       No

C. If you answered "Yes" to question B. provide the date on which you passed:

\_\_\_\_\_

D. Have you successfully administered local anesthesia by infiltration at least 25 times in the 2 year period immediately preceding the date of this application.

Yes       No

If you answered "Yes" to question D. attach a notarized affidavit to this application. You must sign and date the affidavit which must contain the following language: "I solemnly affirm under the penalties of perjury that the contents of the foregoing affidavit are true to the best of my knowledge, information, and belief." (A form Affidavit is attached).

## **SECTION IV - CHARACTER AND FITNESS**

**If you answer "YES" to any question(s) in Section IV – Character and Fitness, attach a separate page with a complete explanation of each occasion. Each attachment must have your name in print, signature, and date.**

- | YES                      | NO                       |   |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | a. Has any licensing or disciplinary board of any jurisdiction or any federal or state entity denied your application for licensure, reinstatement, renewal, or certification to administer either local or block anesthesia, or taken any action against your license, including but not limited to reprimand, suspension, revocation, a fine, or non judicial punishment? |
| <input type="checkbox"/> | <input type="checkbox"/> | b. Have any investigations or charges been brought against you or are any currently pending in any jurisdiction by any licensing or disciplinary board or any federal or state entity?  |
| <input type="checkbox"/> | <input type="checkbox"/> | c. Has your application for a dental hygiene license or certification or other recognition to administer local anesthesia or perform manual curettage in conjunction with scaling and root planing been withdrawn in any state for any reason?  |
| <input type="checkbox"/> | <input type="checkbox"/> | d. Has an investigation or charge been brought against you by a hospital, related institution, or alternative health care system?   |
| <input type="checkbox"/> | <input type="checkbox"/> | e. Have you had any denial of application for privileges, failure to renew your privileges or limitation, restriction, suspension, revocation or loss in privileges in a hospital, related health care facility, or alternative health care system?   |
| <input type="checkbox"/> | <input type="checkbox"/> | f. Have you pled guilty, nolo contendere, had a conviction or receipt of probation before judgment or other diversionary disposition of any criminal act, excluding minor traffic violations?   |
| <input type="checkbox"/> | <input type="checkbox"/> | g. Have you pled guilty, nolo contendere, had a conviction, or receipt of probation before judgment or other diversionary disposition for an alcohol or controlled dangerous substance offense, including but not limited to driving while under the influence of alcohol or controlled dangerous substances?   |
| <input type="checkbox"/> | <input type="checkbox"/> | h. Are there any criminal charges against you in any court of law, excluding minor traffic violations?  |
| <input type="checkbox"/> | <input type="checkbox"/> | i. Do you have a physical or mental condition that currently impairs your ability to practice dental hygiene?   |
| <input type="checkbox"/> | <input type="checkbox"/> | j. Has the use of drugs and/or alcohol resulted in an impairment of your ability to practice your profession?   |
| <input type="checkbox"/> | <input type="checkbox"/> | k. Do you illegally use drugs?  |
| <input type="checkbox"/> | <input type="checkbox"/> | l. Have you surrendered or allowed your license to lapse while under investigation by any licensing or disciplinary board of any jurisdiction, including Maryland, or any federal or state entity?  |
| <input type="checkbox"/> | <input type="checkbox"/> | m. Have you been named as a defendant in a filing or settlement of a malpractice action?  |
| <input type="checkbox"/> | <input type="checkbox"/> | n. Has your employment been affected or have you voluntarily resigned from any employment, in any setting, or have you been terminated or suspended, from any hospital, related health care or other institution, or any federal or state entity for any disciplinary reasons or while under investigation for disciplinary reasons?  |

**Release and Certification:**

I hereby affirm that I have read and followed the above instructions. I hereby certify that all information in this application is accurate and correct.

I agree that the Maryland State Board of Dental Examiners (the Board) may request any information necessary to process my application for recognition to administer local anesthesia by infiltration in Maryland from any person or agency, including but not limited to undergraduate and postgraduate program directors, individual dentists, government agencies, the National Practitioner Data Bank, the Healthcare Integrity and Protection Data Bank, hospitals, and other licensing bodies, and I agree that any person or agency may release to the Board the information requested. I also agree to sign any subsequent release for information that may be requested by the Board.

I agree that I will fully cooperate with any request for information or with any investigation related to my practice of dental hygiene as a licensed dental hygienist in the State of Maryland.

During the period in which my application is being processed, I shall inform the Board within 30 days of any change to any answer I originally gave in this application, any arrest or conviction, any change of address or any action that occurs based on accusations that would be grounds for disciplinary action under the Annotated Code of Maryland, Health Occupations §4-315.

\_\_\_\_\_  
**Applicant Signature**

\_\_\_\_\_  
**Date**

**NOTARY SECTION**

State of \_\_\_\_\_, County of \_\_\_\_\_, Then personally appeared the above named \_\_\_\_\_, and signed and sworn to the truth of the foregoing statements in my presence.

Notary Public: \_\_\_\_\_ My Commission Expires: \_\_\_\_\_

**SEAL**

## Check List for Dental Hygienist Recognition to Administer Local Anesthesia by Infiltration by Virtue of Recognition in Another State



*Please review prior to sending your application package to the Board.*

- 1. Is your application completed front and back?
  - Did you sign and have the application notarized?
  
- 2. Did you enclose the \$ 50 non-refundable fee in a check or money order made payable to the Maryland State Board of Dental Examiners?
  
- 3. Did you enclose a certified copy of your most recent certification from the state of certification identified in your answer to question Section III A. indicating that you hold a certification to administer local anesthesia by infiltration.
  
- 4. Did you enclose a certified examination score from the North East Regional Board indicating that you passed the North East Regional Board Local Anesthesia Examination for Dental Hygienists.
  
- 5. Did you enclose a notarized affidavit indicating that you have successfully administered local anesthesia by infiltration at least 25 times in the past 2 year period immediately preceding the date of this application. (A form Affidavit is attached.)
  
- 6. Did you include documentation of legal name change (i.e.marriage certificate) if the documents sent with the application are in another name?

## **APPLICATION FOR RECOGNITION TO ADMINISTER LOCAL ANESTHESIA BY INFILTRATION BY VIRTUE OF RECOGNITION IN ANOTHER STATE**

**The Board may not process an application until each provision or requirement is met and each document is received. Please ensure that your application is complete before it is submitted.**

**To apply for recognition, submit the Application and enclose the following with your application:**

- A \$50 non-refundable fee.

A certified copy of your most recent certification from the state of certification identified in your answer to question Section III A. indicating that you hold a certification to administer local anesthesia by infiltration.

- A certified examination score from the North East Regional Board indicating that you passed the North East Regional Board Local Anesthesia Examination for Dental Hygienists.

A notarized affidavit indicating that you have successfully administered local anesthesia by infiltration at least 25 times in the past 2 year period immediately preceding the date of this application. (A form Affidavit is attached.)

- If applicable, evidence of legal name change, such as a marriage certificate or court documents.

### **MAIL APPLICATION AND SUPPORTING DOCUMENTS TO:**

Maryland State Board of Dental Examiners  
Spring Grove Hospital Center  
Benjamin Rush Building  
55 Wade Avenue  
Catonsville, MD 21228  
ATTN: Local Anesthesia Recognition

April 2010

# Affidavit

## Board Recognition to Administer Local Anesthesia by Infiltration by Virtue of Recognition in Another State

**Complete This Affidavit Only If You Seek Recognition To Administer Local Anesthesia By Infiltration  
by Virtue of Recognition in Another State**

I, \_\_\_\_\_, a registered dental hygienist in the State of Maryland do  
Print Name  
solemnly affirm under the penalties of perjury that I have successfully administered local anesthesia by  
infiltration at least 25 times in the 2 year period immediately preceding the date of this application.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

### NOTARY

STATE OF \_\_\_\_\_

CITY/COUNTY OF \_\_\_\_\_

I HEREBY CERTIFY THAT on this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_, before me, a Notary Public of  
the State of Maryland and the City/County aforesaid, personally appeared before me

\_\_\_\_\_ and made oath in due form of law that  
signing the foregoing Affidavit was his/her voluntary act and deed.

AS WITNESS my hand and Notarial Seal.

\_\_\_\_\_  
Notary Public

My Commission Expires: \_\_\_\_\_