

**FORM 3**

**DENTAL HYGIENIST**

The University of the State of New York  
THE STATE EDUCATION DEPARTMENT  
Office of the Professions  
Division of Professional Licensing Services  
89 Washington Avenue  
Albany, NY 12234-1000

**CERTIFICATION OF LICENSURE**

**ALL APPLICANTS LICENSED IN OTHER JURISDICTIONS MUST COMPLETE THIS FORM FOR EACH JURISDICTION.**

**APPLICANT INSTRUCTIONS**

1. Complete Section I in ink. Be sure to enter your name as it appears on your Licensure Application (Form 1) and sign and date item 8.
2. Send this form to the appropriate licensing authority of each jurisdiction in which you are or have been licensed as a dental hygienist as directed in the instructions. Be sure to include any fee required.

**SECTION I: APPLICANT INFORMATION**

**1 SOCIAL SECURITY NUMBER**    -

*(Leave this blank if you do not have a U.S. Social Security Number)*

**2 BIRTH DATE**   /   /    
Month Day Year

**3 PRINT FULL NAME**

Last

First

Middle

**4 MAILING ADDRESS** You must notify the Department promptly of any address or name changes.

Line 1

Line 2

Line 3

City

State  Zip Code

Country/Province

**5** If you took a licensing examination in the United States using a different name, enter that name below:

Last \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_

**6** If licensed by examination in the United States, indicate state or territory: \_\_\_\_\_

Date license was issued: \_\_\_\_\_ License number: \_\_\_\_\_

**7** Have you taken the North East Regional Board (NERB) examination?  YES  NO

If yes, give all dates you have taken the examination \_\_\_\_\_

**8** I request and give my permission to the licensing authority to complete the information on this form and send any documentation requested, including that requested on this form, to the New York State Education Department.

Applicant's signature: \_\_\_\_\_ Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
mo. day yr.

**SECTION II : CERTIFICATION OF LICENSURE**

**INSTRUCTIONS TO LICENSING AUTHORITY:** Please complete this section, sign and date the certification and return this form **directly** to the Division of Professional Licensing Services at the address at the end of this form. This form will not be accepted if returned by the applicant.

**1** Name of applicant: \_\_\_\_\_

**2** Profession in which applicant is licensed in your state:  Dental Hygiene  Other: \_\_\_\_\_

**3** License number: \_\_\_\_\_ Date of licensure: \_\_\_\_\_

**4** On what basis was the applicant licensed?  
\_\_\_\_\_

**5** a) Are charges pending against the licensee for professional misconduct, incompetence or negligence?  YES  NO

b) Has the licensee ever been found guilty of such charges or surrendered a professional license?  YES  NO

c) If answer to question 5a or 5b is "yes," please attach a detailed description.

**6** Please specify the state, national and/or regional examinations completed by the applicant \_\_\_\_\_  
\_\_\_\_\_

**7** If the applicant was licensed in your state via a state constructed examination or a regional clinical examination, **other than the North East Regional Boards, please complete the following or attach a copy of the applicant's examination grade report.**

Date of examination: \_\_\_\_\_

Number of days of examination: \_\_\_\_\_

List of clinical subjects conducted on patient: \_\_\_\_\_  
\_\_\_\_\_

List of simulated or written subjects: \_\_\_\_\_  
\_\_\_\_\_

Minimum passing grade in each subject is: \_\_\_\_\_

**NOTE: New York requires a minimum passing score of 75% in each subject area. If scores are not given in percent, please convert.**

**8 CERTIFICATION**

I certify that to the best of my knowledge and belief the information in Section II is a true statement of the record of the applicant named on this form. I further certify that, other than those listed above, this licensing authority has never taken any disciplinary action against this person and that, in so far as the licensing authority has knowledge, there have been no charges preferred nor has any information been presented relating to any question of unprofessional or immoral conduct except as noted in question 5 above.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
mo. day yr.

Print name: \_\_\_\_\_

Title: \_\_\_\_\_

Agency: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

E-Mail: \_\_\_\_\_

**(SEAL OF LICENSING  
AUTHORITY)**

**Do not return this form to the applicant,  
SUBMIT DIRECTLY TO:** 

New York State Education Department, Office of the Professions, Division of Professional Licensing Services, Dental Hygiene Unit, 89 Washington Avenue, Albany, NY 12234-1000.