

## 2019 ALABAMA DENTAL HYGIENE PROGRAM APPLICATION

1. An unmounted passport photograph, 2X2, of applicant taken not more than six months before date of application, **must be securely pasted, NOT STAPLED, to this space** and must not be larger than space provided. Applicant signature required on photograph.

2. Enclose additional passport picture, unsigned for ADHP ID.

Board of Dental Examiners of Alabama  
5346 Stadium Trace Parkway, Suite 112  
Hoover, AL 35244  
(205) 985-7267



ADMINISTRATIVE USE ONLY

Received \_\_\_\_\_

Accepted \_\_\_\_\_

Incomplete / returned \_\_\_\_\_

Denied \_\_\_\_\_

(Use a typewriter or print legibly, and return application in a large envelope. DO NOT FOLD)

Name Mr. or Ms. \_\_\_\_\_

(Last) (First) (Middle) (Social Security Number)

Has your surname ever been changed? \_\_\_\_ If so, give original surname \_\_\_\_\_

I am a bona fide resident of \_\_\_\_\_

(No.) (Street) (City) (State) (Zip) (County)

Home Phone ( ) \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_ Cell phone ( ) \_\_\_\_\_

E-mail \_\_\_\_\_

Complexion \_\_\_\_ Color of Hair \_\_\_\_ Color of Eyes \_\_\_\_ Height \_\_\_\_ Weight \_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Place of Birth \_\_\_\_\_

(Month-Day-Year) (City) (County) (State)

Hepatitis Immunizations \_\_\_\_/\_\_\_\_/\_\_\_\_ OR: Titer Enclosed

(Enclose documentation of: 1<sup>st</sup> 2<sup>nd</sup> 3<sup>rd</sup>)

EDUCATION: Name as listed on transcript: \_\_\_\_\_

High School: \_\_\_\_\_

Graduation Year High School Name City State

GED: \_\_\_\_\_

**Incomplete Forms Will Be Returned - Must Be Postmarked By April 30<sup>th</sup>**

Completion Date

Program administered by

Official high school transcript or GED scores.

Enclosed

Yes No

Will arrive under separate cover

Yes No

**OPTIONAL EDUCATION:**

A. Secondary Education: \_\_\_\_\_  
College/Institution

\_\_\_\_\_ Dates of enrollment \_\_\_\_\_ Graduation date \_\_\_\_\_ Degree

B. Dental Assisting Education \_\_\_\_\_  
College/Institution

\_\_\_\_\_ Dates of enrollment \_\_\_\_\_ Graduation date \_\_\_\_\_ Degree

**EMPLOYMENT HISTORY:**

**Current Employer: Dr. \_\_\_\_\_ LNO \_\_\_\_\_ Company/Practice \_\_\_\_\_**  
Name and license # of dentist making application for ADHP training permit

Date Certified as ADHP Dentist/Instructor \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Office Mailing Address: \_\_\_\_\_  
(Street) (City) (State) (Zip) (County)

Applicant current employment date \_\_\_\_\_ to present

Total number of months employed as full time chair side assistant? \_\_\_\_\_ Part time \_\_\_\_\_

Past Employers: \_\_\_\_\_ Employment date \_\_\_\_\_

\_\_\_\_\_ Employment date \_\_\_\_\_

Applicant CPR Certification Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_ **(INCLUDE COPY OF CARD)** Course Date for Infectious

Disease Training \_\_\_\_ / \_\_\_\_ / \_\_\_\_ **(INCLUDE CERTIFICATE)**

Has ADHP permit ever been issued for applicant previously? NO YES

If yes, previous enrollment name if different \_\_\_\_\_

If yes, previous enrollment dentist-instructor \_\_\_\_\_ Enrollment Date \_\_\_\_\_

**Please circle appropriate response: If yes, furnish (on separate page) a written statement. As to convictions or actions against license, include dates, name and nature of offense, identification of court or licensing entity, certified copy of court records, and any penalty and punishment imposed.**

- |   |       |     |
|---|-------|-----|
| 1. Have you ever been convicted of a felony or a misdemeanor involving moral turpitude?                               | No    | Yes |
| 2. Have you ever been convicted of violating any federal or state law relating to narcotics or controlled substances? | No    | Yes |
| 3. Have you ever undergone treatment for any substance or alcohol abuse or problems?                                  | No    | Yes |
| 4. Have you been afflicted with a contagious or infectious disease?<br>(Do not list childhood diseases.)              | No    | Yes |
| 5. Have you ever been refused or denied a license or permit in any state?   | No    | Yes |
| 6. List all states in which you hold a hygiene license.   | <hr/> |     |
| 7. Has any action been taken against your license in any other state?   | No    | Yes |
| 8. Are there any action pending against your license?   | No    | Yes |

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**PLEASE READ CAREFULLY**

**Dentist - Instructor and Student - Hygienist Agreement**

Students of the Alabama Dental Hygiene Program **are not** students of the University of Alabama, School of Dentistry. The University of Alabama, School of Dentistry allows the use of its facilities. Attendance in this program does not allow you to represent yourself as having attended or graduated from UAB. There is **no college credit** given for participation for this program.

1. Applicants for the Alabama Dental Hygiene Program must be more than 18 years of age, of good moral character, and must fulfill all prescribed requirements of the Alabama Dental Hygiene Program as stated in Board Rule 270-X-3.04
2. The dentist-instructor **must** hold valid instructor-certification status.

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3. All ADHP students must have had at least twenty-four (24) full months of full time employment as a dental assistant, or the equivalent of twenty-four (24) full months in Part-time employment week within the three (3) years previous to the student's enrollment in the ADHP.
4. Full time employment with the dentist-instructor is mandatory for continued enrollment in the ADHP. (Minimum 30 hrs. per week or three and one-half (3 1/2) days, Unauthorized change in employment status by either party will result in termination of ADHP training permit.
5. The required fee is payable to the Board of Dental Examiners of Alabama by check or money order and must accompany completed application prior to April 30, 2018, refund of fees defined in 270-X-3.04 (11).
6. The ADHP training permit will be valid after completion of the August academic session and remain valid only with total compliance with all requirements of the ADHP as stated in Board Rule 270-X-3.04.
7. Attendance at each academic session is mandatory. Please review the enclosed academic schedule prior to enrollment. No leaving early.
8. The student-hygienist must have an overall grade point average of 75% to successfully complete and pass the program.
9. During the program year any grade point average below 75% shall be considered Academic Probation and should be carefully evaluated and monitored by the student-hygienist and the dentist-instructor.
10. A minimum of 150 prophys shall be completed prior to close of the program year. No more than 50 shall be on patients with deciduous teeth only.
11. The dentist/instructor is welcome to attend any ADHP session to provide study support to a student. Continuing education credit will be earned.
12. A pre-entrance exam shall be completed and returned with this application.
13. Textbook assignments are expected to be completed prior to each academic session.
14. Students will be randomly audited to provide documentation of compliance with employment requirements, and/or prophy counts.
15. On successful completion of the ADHP the candidate is eligible to apply for the Alabama Dental Hygiene Licensing Exam, administered by a Regional Testing Agency.

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I agree to provide the patients, materials and instruction as required of me as an Alabama Dental Hygiene Program Dentist-Instructor.

I understand that according to the laws of the State of Alabama regulating the training of dental hygienists, this application for permit to employ a student dental hygienist is for the specific employment of the above named student dental hygienist and that I am not permitted to use it beyond the expiration date. I understand that full time employment (minimum 30 hrs. per week) is required for participation in the ADHP. (Bd. Rule 270-X-3.04)

I will return the permit to train the student dental hygienist to the Board of Dental Examiners of Alabama when he or she appears for Board Examination, fails the Program or leaves my employment.

My signature confirms that I have read and understand the requirements for participation in the Alabama Dental Hygiene Program.

Dentist - Instructor \_\_\_\_\_  
*Signature of Dentist/Instructor* LNO Date

I agree to comply with all relevant Federal and State laws, including but not limited to the Alabama Dental Practice Act, as well as the rules and regulations of the Board of Dental Examiners of Alabama.

In making this application, I certify that the statements given in this application are true and correct and that I have satisfied all requirements set forth in the Alabama Dental Practice Act and the rules of the Board of Dental Examiners of Alabama.

\_\_\_\_\_  
(Signature of Applicant) Date

The State of \_\_\_\_\_

The County of \_\_\_\_\_

\_\_\_\_\_, being duly sworn by me on his/her oath that all facts, statement and answers contained in this application are true and correct in every respect, and that the attached photograph is a true likeness of the applicant.

Sworn and subscribed before me this \_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_, to certify which witness my hand and official seal of office.

My commission expires \_\_\_\_\_

(Seal)

\_\_\_\_\_  
(Signature of Notary Public)

County of \_\_\_\_\_ State of \_\_\_\_\_

## Certificate of Moral Character

To be completed by two reputable references, dentists when possible. (NOT BY THE DENTIST-INSTRUCTOR), who have known the applicant for at least two years.

THIS CERTIFIES, that I have personally known \_\_\_\_\_

for \_\_\_\_ years and know him or her to be of good moral character, and hereby recommend him or her to the Board of Dental Examiners of Alabama as being worthy of the privilege of practicing Dental Hygiene in Alabama, pursuant to law.

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Name			(Signature)		
Address	(No.)	(Street)	(City)	(State)	(Zip)
Occupation				Date	

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Name			(Signature)		
Address	(No.)	(Street)	(City)	(State)	(Zip)

Occupation

Date

## Documentation of Disability Related Needs

(OPTIONAL)

If you have a learning disability, a psychological disability, or other hidden disability that requires an accommodation in testing, please have this section completed by an appropriate professional (education professional, doctor, psychologist, psychiatrist to certify that your disabling condition requires the requested test accommodation.

The information requested below and any documentation regarding your disability and your need for accommodation in testing will be considered strictly confidential and will not be shared with any outside source without your express written permission.

**IF YOU HAVE EXISTING DOCUMENTATION OF HAVING THE SAME OR SIMILAR ACCOMMODATION PROVIDED TO YOU IN ANOTHER TEST SITUATION, YOU MAY SUBMIT SUCH DOCUMENTATION INSTEAD OF HAVING THIS PORTION OF THE FORM COMPLETED.**

I have known \_\_\_\_\_ since \_\_\_\_\_ in my  
(Test applicant)

capacity as \_\_\_\_\_  
(Professional title) (Date)

The applicant has discussed with me the nature of the test to be administered. It is my opinion that because of this applicant's disability, he/she should be accommodated by providing the following: (check all that apply) **MUST DECLARE DISABILITY AT TIME OF APPLICATION.**

\_\_\_\_\_ Reader

\_\_\_\_\_ Scribe/amanuensis

\_\_\_\_\_ Other (please specify)

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

Date: \_\_\_\_\_ License # (if applicable) \_\_\_\_\_  
The Board of Dental Examiners of Alabama is an Equal opportunity employer and does not discriminate on the basis of disability, race, sex, national origin or religion in employment or in the provision of or access to its programs, services or activities.

2019-2020  
Alabama Dental Hygiene Enrollment

Education fee	\$ 375.00
Training Permit fee	\$ 300.00
Instructional Materials (+ Training video)	<u>\$ 325.00</u>
<b>Total</b>	<b>\$ 1000.00</b>

**Completed pre-test, answered & enclosed**                      **Yes**                      **No**

Application and fees due by April 30, 2019

Please make check or money order payable: Board of Dental Examiners of Alabama  
5346 Stadium Trace Parkway, Suite 112  
Hoover, AL 35244

**Check number:** \_\_\_\_\_                      **Amount:** \_\_\_\_\_

**Check issued by:** \_\_\_\_\_

**Applicant name:** \_\_\_\_\_