

Incomplete Applications Will Not Be Considered for Acceptance in the ADHP  
Application Must Be Postmarked by April 30

## 2022 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  
2229 Rocky Ridge Road  
Birmingham, AL 35216  
(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 (\_\_\_\_) \_\_\_\_\_

Email address for all ADHP correspondence \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Place of Birth \_\_\_\_\_  
(Month-Day-Year) (City) (County) (State or foreign country)

Hepatitis Immunizations \_\_\_\_/\_\_\_\_/\_\_\_\_ \_\_\_\_/\_\_\_\_/\_\_\_\_ \_\_\_\_/\_\_\_\_/\_\_\_\_  
\*MUST enclose documentation of: 1<sup>st</sup> 2<sup>nd</sup> 3<sup>rd</sup>)

\*OR: Titer Enclosed

Applicant CPR Certification Date \_\_\_\_/\_\_\_\_/\_\_\_\_ (MUST INCLUDE COPY OF CARD)

Course Date for Infectious Disease Training \_\_\_\_/\_\_\_\_/\_\_\_\_ (MUST INCLUDE CERTIFICATE)

Has an ADHP permit ever been issued for you previously? NO YES

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

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

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

High School: \_\_\_\_\_  
Graduation Year                      High School Name                      City                      State

GED: \_\_\_\_\_  
Completion Date                      Program administered by

You MUST enclose an official copy of your high school transcript or GED diploma.

OTHER EDUCATION (if any):

A. Postsecondary 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: Full name of Dr. \_\_\_\_\_ License #: \_\_\_\_\_**  
(Name and license # of dentist making application for ADHP training permit)

**Company/Practice Name:** \_\_\_\_\_

Practice classification (circle one): Private    Group    Corporate

Area of practice (circle one): General    Pediatric    Orthodontics    Prosthodontics  
Periodontics    Oral Surgery    Endodontics

Dentist-employer's preferred email address: \_\_\_\_\_

\*To be used for ALL ADHP correspondence (including grades)

Date Certified as ADHP Dentist-Instructor    \_\_\_\_ / \_\_\_\_ / \_\_\_\_ (month/day/year)

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

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Applicant current employment date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ (month/day/year) to present

Total number of months you have been employed as a full-time chair side assistant: \_\_\_\_\_ Part time \_\_\_\_\_

Past Employers: 1) \_\_\_\_\_

Employment beginning date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ End date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ (month/day/year)

2) \_\_\_\_\_ Employment beginning date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ End date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

You may use an additional sheet to add employers.

**Please circle appropriate response: If yes, furnish (on a 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 arrested or convicted for a felony or a misdemeanor involving moral turpitude?   | No | Yes |
| 2. Have you ever been arrested or convicted for violating any federal or state law relating to alcohol, 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: _____  |    |     |
| 7. Has any action been taken against your license in any other state?  | No | Yes |
| 8. Are there any actions pending against your license?   | No | Yes |

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**PLEASE READ CAREFULLY**

**Dentist-Instructor and Student Agreement**

Students of the Alabama Dental Hygiene Program **are not** students of the University of Alabama School of Dentistry. 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 at least 19 years of age, of good moral character, and must fulfill all prescribed requirements of the Alabama Dental Hygiene Program as stated in Board Rule, Ala. Admin. Code r. 270-X-3-.04.
2. The dentist-instructor **must** hold valid and current instructor-certification status.
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-time months in part-time employment 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—a minimum of 30 hours or three and one-half (3½) days per week. A change in employment status not approved by the Board can result in termination of the ADHP training permit and dismissal from the program.
5. The required fee is payable to the Board of Dental Examiners of Alabama by cashier's check or money order, and must accompany a completed application postmarked by April 30, 2022. Conditions for fee refunds are set forth in Board Rule 270-X-3-.04(9).
6. The ADHP training permit will be valid after completion of the August academic session and will remain valid only with total compliance with all requirements of the ADHP as stated in Rule 270-X-3-.04.
7. **Attendance at each academic session is mandatory**. Please review the academic schedule prior to enrollment. Arriving late and leaving early are not allowed.
8. The student-hygienist must have an overall grade point average of 75% to graduate.
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. The student must complete a minimum of 150 prophies prior to close of the program year. No more than 50 may be on patients with deciduous teeth only.
11. You must complete the textbook assignments prior to each academic session.
12. Students will be randomly audited to provide documentation of compliance with employment requirements and/or prophy counts.
13. Upon successful completion of the ADHP, the candidate is eligible to apply for the Alabama Dental Hygiene Licensing Exams, administered by regional testing agencies.

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**FOR THE DENTIST-INSTRUCTOR:**

I agree to provide the patients, materials, and instruction required of me as an Alabama Dental Hygiene Program Dentist-Instructor. **I confirm that I can provide the ADHP student with the opportunity to perform, and will require the student to perform, a minimum of 150 prophylactic patient treatments during the ADHP course year. I confirm further that the majority of the patients the ADHP student treats will have subgingival calculus, providing the student the opportunity to become proficient at detection and removal of subgingival calculus.**

I understand that according to the laws of the State of Alabama regulating the training of dental hygienists, this application for a 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 (30 hours or 3½ days per week) is required for participation in the ADHP. (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 License # 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 ADHP Applicant Date

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

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

\_\_\_\_\_, being duly sworn, deposes and says that all facts, statements, 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 \_\_\_\_\_

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## Certificate of Moral Character

To be completed by **TWO** reputable references, dentists, when possible (NOT THE DENTIST-INSTRUCTOR), who have known the applicant for at least two years. **Print and enclose TWO copies of this page**, and provide one to each of your two affiants.

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
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Address (No.)	(Street)	(City)	(State)	(Zip)
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Occupation	Date
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## 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 educational program and the tests 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).

\_\_\_\_\_ 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.

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2022-2023  
Alabama Dental Hygiene Enrollment

<b>Education fee</b>	<b>\$500.00</b>
<b>Training Permit fee</b>	<b>\$325.00</b>
<b>Instructional Materials (+ Training video)</b>	<b>\$450.00</b>
<b>ADHP Application Fee</b>	<b><u>\$300.00</u></b>
<b>Total</b>	<b>\$1575.00</b>

Application and total fees due by April 30, 2022; make cashier's check or money order payable to:

Board of Dental Examiners of Alabama  
2229 Rocky Ridge Road  
Birmingham, AL 35216

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**To be completed by ADHP staff:**

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

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

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