VERIFICATION OF PRACTICE HOURS
ADA Accredited Program
Post-Graduation
Faculty – Hours Verification
Course of Study
Pathway 2

EXPANDED PRACTICE PERMIT
CERTIFICATION OF CLINICAL PRACTICE

Dental Hygienist Name: _____ **License No.** _____

Supervising Faculty Name: _____ **Telephone Number:** _____
Print Name

Dental or Dental Hygiene Program: _____

Location/Address: _____
Address City State Zip Code

From _____ **to** _____ **TOTAL HOURS WORKED**_____
Date Date

I certify that while I was a faculty member or an adjunct faculty member, for the program named above, and while under my direct supervision, the above dental hygienist practiced on patients or residents of the following facilities or programs who, due to age, infirmity or disability, were unable to receive regular dental hygiene treatment:

Please indicate the catagory(s) in which the above named dental hygienist practiced:
(Check all that apply)

- ☐ (A) Nursing homes as defined in ORS 678.710;
- ☐ (B) Adult foster homes as defined in ORS 443.705;
- ☐ (C) Residential care facilities as defined in ORS 443.400;
- ☐ (D) Adult congregate living facilities as defined in ORS 441.525;
- ☐ (E) Mental health residential programs administered by the Oregon Health Authority;
- ☐ (F) Facilities for persons with mental illness, as those terms are defined in ORS 426.005;
- ☐ (G) Facilities for persons with developmental disabilities, as those terms are defined in ORS 427.005;
- ☐ (H) Local correctional facilities and juvenile detention facilities as those terms are defined in ORS 169.005, regional correctional facilities as defined in ORS 169.620, youth correction facilities as defined in ORS 420.005, youth care centers as defined in ORS 420.855, and Department of Corrections institutions as defined in ORS 421.005; or
- ☐ (I) Public and nonprofit community health clinics.
- ☐ (b) Adults who are homebound.
- ☐ (c) Students or enrollees of nursery schools and day care programs and their siblings under 18 years of age, Job Corps and other similar employment training facilities, primary and secondary schools, including private schools and public charter schools, and persons entitled to benefits under the Women, Infants and Children Program.
- ☐ (d) Patients in hospitals, medical clinics, medical offices or offices operated or staffed by nurse practitioners, physician assistants or midwives.
- ☐ (e) Patients whose income is less than the federal poverty level.
- ☐ Other populations that the Oregon Board of Dentistry determines are underserved or lack access to dental hygiene services.

By signing below I certify that the information provided on this form is true and correct.

Signature of Faculty: _____ Date: _____

Return this form directly to the Oregon Board of Dentistry, 1500 SW 1st Avenue, Suite 770, Portland OR 97201.

This form may be duplicated

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VERIFICATION OF FACULTY OR ADJUNCT FACULTY MEMBER
FROM ADA ACCREDITED PROGRAM
PATHWAY 2

Dental or Dental Hygiene Program: _____

Location/Address: _____

Telephone: _____

Faculty or Adjunct Faculty Name: _____

Faculty Employed/Appointment Date(s): From _____ to _____.

By signing below I certify that the information provided on this form is true and correct.

_____
Program Director's Signature

_____
Type or Print Name

_____
Date

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