Oregon
Tina Kotek, Governor

Board of Dentistry
1500 SW 1st Ave, Ste 770
Portland, OR 97201-5837
(971) 673-3200
Fax: (971) 673-3202
www.oregon.gov/dentistry

DENTAL HYGIENE EXPANDED PRACTICE PERMIT

A licensed dental hygienist who holds a valid, unrestricted Oregon dental hygiene license and who meets the requirements of ORS 680.200 may practice as an Expanded Practice Dental Hygienist after obtaining a permit from the Board. Please review ORS 680.200 and ORS 680.205, and OAR 818-035-0065 and OAR 818-035-0066 for the statutes and rules related to the Expanded Practice Permit.

INSTRUCTIONS - PATHWAY II

To obtain an Expanded Practice Permit, you must print and mail this application along with the required fee to the following address:

Oregon Board of Dentistry
Unit 23
PO Box 4395
Portland, OR 97208

The following must be submitted with this application:

1. **Permit Fee - $75.00:** Must be in the form of a personal check, cashier's check or money order made payable to the Oregon Board of Dentistry. Your fee must be enclosed in the same envelope with your application, and mailed to the address indicated above.

2. **Healthcare Provider Basic Life Support (BLS) Certification:** Enclose documentation showing that you hold a valid and current Health Care Provider BLS certification.

3. **Proof of Professional Liability Coverage:** Submit documentation of current professional liability insurance coverage (either your own policy, or your employer's. Please note that if using your employer's policy, you will not be permitted to use your EPP anywhere other than the clinic under which you are insured).

4. **Verification of Practice Hours – Pre-Graduation Education (Page 3 of application):** This verification form must be submitted from a formal, post-secondary educational program accredited by the Commission on Dental Accreditation of the American Dental Association directly to the Board, of the number of hours you practiced on patients described in ORS 680.205 while under the direct supervision of a member of the faculty.

OPTIONAL:

Collaborative Agreement (Page 4 of application): An agreement between the expanded practice dental hygienist and a dentist(s) setting forth the agreed-upon scope of the dental hygienist's practice in regards to the following procedures, the agreement must be drafted and signed by both parties, attached to the Verification of Collaborative Agreement form (also signed by both parties) which is included in this packet, and submitted to the Board.

a. Administering local anesthesia;
b. Administering temporary restorations with or without excavation;
c. Prescribing prophylactic antibiotics and nonsteroidal anti-inflammatory drugs specified in the agreement;
d. Performing interim therapeutic restorations after diagnosis by a dentist; and
e. Referral parameters.

A Collaborative Agreement is **not** required to apply for an Expanded Practice Permit.

If you have questions, please email Information@obd.oregon.gov or call (971) 673-3200

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MAIL TO:
OREGON BOARD OF DENTISTRY
Unit 23
PO Box 4395
Portland, OR 97208-4395

Rev. Code 2142

APPLICATION FOR DENTAL HYGIENE EXPANDED PRACTICE PERMIT
PATHWAY 2
DENTAL HYGIENIST
Fee: $75.00

Name _____ License No. _____

Mailing Address _____

City _____ State _____ Zip _____

Email _____

I have successfully completed a course of study approved by the Board that includes at least 500 hours of dental hygiene practice on patients described in ORS 680.205 while under the direct supervision of a member of the faculty of a dental or dental hygiene program accredited by the Commission on Dental Accreditation of the American Dental Association.

Name of Program: _____

Date of Graduation: _____

Hours of practice on patients described in ORS 680.205: _____

Professional Liability Insurance Carrier: _____

Name of Insured: _____

Policy Number: _____ Expiration: _____

By signing below I certify that I have met all requirements for an Expanded Practice Permit. I further certify that the information given on this form is true and correct. I understand that any falsification could result in denial, suspension, and/or revocation of my dental hygiene license.

Signature _____ Date _____

Expanded Practice Permit
Practice Settings

Name: _____ License Number: _____

Please indicate the location(s) in which you plan to practice:
(Check all that apply)

(a) Patients or residents of the following facilities or programs who, due to age, infirmity or disability, are unable to receive regular dental hygiene treatment:

☐ (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.

☐ General/Specialty Practice.

☐ Not currently practicing.

Signature: _____ Date: _____

VERIFICATION OF PRACTICE HOURS
ADA Accredited Program
Pre-Graduation
Course of Study
Pathway 2

EXPANDED PRACTICE PERMIT
CERTIFICATION OF CLINICAL PRACTICE

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

Program Director's Name: _____ **Telephone Number:** _____
Print Name

Dental Hygiene Program: _____

Location/Address: _____
Address City State Zip Code

From _____ **to** _____ **TOTAL HOURS COMPLETED**_____
Date Date

I certify that the above named dental hygienist while in our dental hygiene program, 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 while under the direct supervision of a faculty member:

Please indicate the category(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 Program Director: _____ 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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Oregon Board of Dentistry

Expanded Practice Dental Hygiene Permit

Verification of Collaborative Agreement

I _____, License No. _____ have entered into a collaborative agreement with _____, a dental hygienist with an expanded practice permit, License No. _____. The collaborative agreement sets forth the agreed-upon scope of the dental hygienist's practice with regard to the following:

Check all that apply:

- ☐ Administer local anesthesia.
- ☐ Administer temporary restorations with or without excavation.
- ☐ Prescribing prophylactic antibiotics and non-steroidal anti-inflammatory drugs:
    - On your Collaborative Agreement you must specify either ALL prophylactic antibiotics or non-steroidal anti-inflammatory drugs, or if limiting prescribing abilities, list specific drugs allowed.
- ☐ Perform Interim Therapeutic Restorations after diagnosis by a dentist.
- ☐ Referral Parameters.

I understand that this agreement will remain in effect with the Oregon Board of Dentistry (OBD) until I submit a written change. If any changes are made to this agreement, a new verification and copy of the agreement must be submitted to the OBD immediately.

I attest that **a copy of the Collaborative Agreement, drafted and signed by both parties, is attached to this verification**. I understand that failure to provide a copy of the agreement with the verification will result in the verification form being rejected and returned.

Dentist's Signature: _____ Date: _____

Dental Hygienist's Signature: _____ Date: _____