Department *of* Commerce
Division *of* Professional Licensing

Dental Hygienist & Dental Assistant: Addition of Expanded Function Specialty

(please select the expanded function for which you are applying)

☐ Administration of Botulinum Toxin ☐ Removal of Coronal Adhesive ☐ Placement of Direct Restorations

APPLICANT INFORMATION

Full Legal Name: _____
First *Middle* *Last*

All Previous Legal Names: _____

DOPL Licenses Held (if applicable): _____

SSN:* _____ Date of Birth: _____ Gender ☐ Male ☐ Female

** If you don't have a social security number, please follow the instructions on the last page.*

Address: _____
Street Address (including Apt/Unit/Ste #) and/or PO Box

City: _____ State: _____ Zip: _____

Phone: (_____) _____ – _____ Email: _____

Note: All Division notices and communication will be sent to this email.

Please select one:

☐ I am a United States citizen or a non-citizen of the United States who is lawfully present.

☐ I am a foreign national not physically present in the United States.

☐ None of the above, please explain: _____

Driver License or State ID Card: _____ _____ _____
State of Issue *License Number* *Expiration Date*

NOTE: If you do not hold a US Driver License or a US State ID, you must present a legible copy of your current and valid government issued document(s) showing evidence of lawful presence in the United States.

AFFIDAVIT AND RELEASE

I certify that I have completed the education and training as required in Utah Code 58-69-808.

I certify that to the best of my knowledge, the information contained in the application and all supporting document(s) are true and correct, and discloses all material facts regarding the applicant, and that I will update or correct the application as necessary, prior to any action on my application.

I authorize all persons, organizations, governmental agencies, or any others not specifically listed, which are set forth directly or by reference in this application, to release to the Department of Commerce, State of Utah, any files, records, or information of any type reasonably required for the Department to properly evaluate my qualifications for licensure/certification/registration by the State of Utah.

I understand that I am responsible to update the Department of any changes relating to my application/license/certification/registration.

I understand that if the application is not complete at the time of submission, it will delay approval and could result in a denial.

I declare under criminal penalty under the law of Utah that this application is true and correct.

Signature of Applicant: _____ Date: _____

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PRIVACY NOTICE

The information you provide on this form will be used to determine your eligibility for a license, registration, or certification in Utah. Failure to provide complete information as requested will result in the denial of your request as incomplete.

Information provided in this form is retained in accordance with state record retention laws. For specific information about the records retention for this form, please visit https://dopl.utah.gov/records

To comply with legal and regulatory requirements, we may share limited information about your license, registration, or certification with authorized parties. This may include government agencies, national databases, and contracted vendors. Shared information may include issue date, status, expiration date, disciplinary actions, and your name or other direct identifiers.

We may also share aggregated and de-identified data (e.g., education levels, exam pass rates, length of licensure, etc.) with relevant stakeholders for data analysis and reporting purposes.

ACKNOWLEDGEMENT:

Your signature acknowledges receipt of this information.

Authorized Signature:_____ Date: _____

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Verification of Education Dental Auxiliary Expanded Function Administration of Botulinum Toxin

To be submitted by dental hygienist applicants who completed an approved formal education program for an expanded function certification as outlined in Utah Admin. Code R156-69-808a

APPLICANT INFORMATION:

Full Legal Name: _____ _____ _____
First *Middle* *Last*

Utah License Number: _____

EDUCATION:

Start Date: _____ End Date: _____
MM/DD/YYYY *MM/DD/YYYY*

Please verify the applicant's training hours for the Delegated Maxillofacial Administration of Botulinum Toxin certification:

- Approved *20 hour* course on administering botulinum toxin; Certificate of Completion or course letter must be included document must include:

☐ the name of the attendee;
☐ the name of course provider;
☐ the name of instructor;
☐ the date of the course;
☐ the title of the course;
☐ the number of course hours

ATTESTATION: (to be completed by supervising dentist)

By signing below, I certify that the applicant named above has successfully completed a program of education and training as outlined in Utah Admin. Code R156-69-808a; including at least 8 botulinum toxin injections on a live patient under direct supervision. I further certify that the applicant is qualified and competent to perform the delegated maxillofacial administration of botulinum toxin

I declare under criminal penalty under the law of Utah that this application is true and correct.

Signature: _____ Date: _____

Printed Name: _____

Utah License Number: _____

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Verification of Education Dental Auxiliary Expanded Function Placement of Direct Restorations

Select one: [ ] Dental Hygienist [ ] Dental Assistant

To be submitted by applicants (dental hygienists or dental assistants) who completed an approved formal education program of at least 172 hours for an expanded function certification as outlined in Utah Admin. Code R156-69-808b
** In instances where qualified education has been acquired from multiple sources, it is mandatory to submit separate copies of this form for each source.

APPLICANT INFORMATION:

Full Legal Name: _____ _____ _____
First *Middle* *Last*

SSN:* _____ Date of Birth: _____ Gender: ☐ Male ☐ Female
* If you don't have a social security number, please follow the instructions on the last page.

Address: _____
Street Address (including Apt/Unit/Ste #) and/or PO Box

City: _____ State: _____ Zip: _____

Phone: (_____) _____– _____ Email: _____
Note: All Division notices and communication will be sent to this email.

EDUCATION: (To be completed by the Official Program Representative:)

Name of Program, School, or Course Provider: _____

Start Date: _____ End Date: _____
MM/DD/YYYY *MM/DD/YYYY*

Please list the total number of hours of training in each of the following categories for the Placement of Direct Restorations certification:

Topics	Didactic Hours	Clinical Hours
Foundational anatomy, physiology, morphology, and occlusion *(required 6 didactic / 12 clinical)*:		
Restorative materials, armamentarium, and instrumentation *(required 8 didactic / 20 clinical)*:		
Adhesive dentistry and tooth isolation *(required 6 didactic / 16 clinical)*:		
Direct restoration placement and finishing for Class I through VI *(required 10 didactic / 40 clinical)*:		
Caries removal, liners, and bases *(required 4 didactic / 10 clinical):*		
Law and rule *(required 1 didactic):*		NA
Professional ethics *(required 1 didactic)*:		NA
Clinical integration and simulated patient care *(required 8 didactic / 30 clinical)*:		

Total hours of all training (must be at least 172 hours): _____

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Verification of Education Dental Auxiliary Expanded Function Placement of Direct Restorations

ATTESTATION:

By signing below, I certify that the applicant named above has successfully completed a program of education and training as outlined in Utah Admin. Code R156-69-808b. I further certify the course included a Comprehensive knowledge-based written exam and Competency examinations. I further certify that the applicant is qualified and competent to perform the placement of direct restorations.

Select one of the following options, ensuring that the completed education program complies with Utah Code R156-69-808b(2)(b):

CODA accredited ____ DANB recognized ____ DOPL recognized ____

I declare under criminal penalty under the law of Utah that this application is true and correct.

Name of Administrator or Program Director (Please Print): _____

Title/Position Held: _____

Email Address: _____

Signature: _____ **Date:**_____

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Verification of Education Dental Auxiliary Expanded Function Removal of Coronal Dental Adhesive

Select one: [ ] Dental Hygienist [ ] Dental Assistant

To be submitted by applicants (dental hygienists or dental assistants) who completed an approved formal education program of at least 22 hours for an expanded function certification as outlined in Utah Admin. Code R156-69-808c

APPLICANT INFORMATION: (to be completed by the applicant)

Full Legal Name: _____ _____ _____
First *Middle* *Last*

SSN:* _____ Date of Birth: _____ Gender: ☐ Male ☐ Female
* If you don't have a social security number, please follow the instructions on the last page.

Address: _____
Street Address (including Apt/Unit/Ste #) and/or PO Box

City: _____ State: _____ Zip: _____

Phone: (_____) _____ – _____ Email: _____
Note: All Division notices and communication will be sent to this email.

EDUCATION: (To be completed by the Official Program Representative:)

Name of Program, School, or Course Provider: _____

Start Date: _____ End Date: _____
MM/DD/YYYY *MM/DD/YYYY*

Please list the total number of hours of training in each of the following categories for the Removal of Coronal Dental Adhesive certification:

Foundational knowledge of anatomy, physiology, and morphology (required 3 didactic): _____

Appliances, restorations, and materials (required 2 didactic): _____

Dental Instruments (required 4 didactic): _____

Techniques for coronal adhesive polishing (required 3 didactic): _____

Case management (required 1 didactic): _____

Law and rule, and Professional Ethics (required 1 didactic): _____

Clinical integration and simulated patient care (required 2 didactic): _____

Clinical integration and simulated patient care (required 6 clinical): _____

Total hours of all training (must be at least 22 hours): _____

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Verification of Education Dental Auxiliary Expanded Function Removal of Coronal Dental Adhesive

ATTESTATION:

By signing below, I certify that the applicant named above has successfully completed a program of education and training as outlined in Utah Admin. Code R156-69-808c. I further certify that the applicant is qualified and competent to perform the removal of coronal dental adhesive.

Select one of the following options, ensuring that the completed education program complies with Utah Code R156-69-808c(2)(b):

CODA accredited ___ DANB recognized ___ UAO recognized ___

I declare under criminal penalty under the law of Utah that this application is true and correct.

Name of Administrator or Program Director (Please Print): _____

Title/Position Held: _____

Email Address: _____

Signature: _____ **Date:** _____

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APPLICATION CHECKLIST AND INSTRUCTIONS

This checklist is for your convenience, you do not need to include it with your application.
NOTE: Incomplete applications will be denied.

Your application is classified as a public record and may be available for inspection by the public, except with regard to the release of information, which is sub-classified as controlled, private, or protected under the Government Records Access and Management Act or restricted by other law.

If you do not have a valid Social Security number, you must submit your Individual Taxpayer Identification Number (ITIN), Alien Registration Number (A-number), or a copy of an unexpired government issued passport from your country of residence and an intent-to-hire letter from a Utah based employer (Utah Code § R156-1-301). Submission of the above documents may require additional documents to demonstrate lawful presence (Utah Code § 63G-12-402 (3)(k)).

ALL APPLICANTS

The following items are required for all applicants to complete the application:

- ☐ $60.00 non-refundable application processing fee, made payable to "DOPL"
- ☐ A copy of your current CPR, BCLS/BLS, or ACLS/PALS certification.

BOTULINIUM TOXIN 808a

In addition to the items required for all applicants, the following items are required to complete your application:

- ☐ Hold a Utah Dental Hygiene license for at least 2 years AND
- ☐ Submit a copy of your CV/Resume to verify 3,500 hours of work experience.
- ☐ Submit competency letter from a qualified supervising dentist (page 3)
- ☐ Submit Certificate of Completion or course letter that meets R156-69-301a(5)(b) and R156-69-304a(11); document must include the following:
  - at least ten hours of training on administering botulinum toxin for cosmetic purposes (a course description maybe requested to determine all topics required in rule are included in the completed course)
  - at least ten hours of training on administering botulinum toxin for treating medical conditions

DIRECT RESTORATION 808b

In addition to the items required for all applicants, the following items are required to complete your application:

- ☐ Hold a Utah Dental Hygiene license or submit a copy of your CV/Resume to verify at least 3,500 hours of work experience as a Dental Assistant
- ☐ Verification of Education (pages 4-5)
- ☐ Official Score report from Division Approved Examination

ADHESIVE REMOVAL 808c

In addition to the items required for all applicants, the following items are required to complete your application:

- ☐ Hold a Utah Dental Hygiene license or submit a copy of your CV/Resume to verify at least 3,500 hours of work experience as a Dental Assistant
- ☐ Verification of Education from Division Approved course (pages 6-7)

If you have questions, please contact the Division at 801-530-6628 or by email at B9@Utah.gov.

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