



New Mexico Regulation and Licensing Department

BOARDS AND COMMISSIONS DIVISION

New Mexico Board of Dental Health Care and

New Mexico Dental Hygienist Committee

P.O. Box 25101 ▪ Santa Fe, New Mexico 87505

(505) 476-4680 ▪ Fax (505) 476-4545 ▪ www.RLD.state.nm.us/boards/dental_health_care.aspx

REQUIREMENTS FOR LOCAL ANESTHESIA CERTIFICATION BY WREB EXAMINATION

All licensing information provided is public information

For certification in local anesthesia by examination you must possess the following qualifications and submit the required fees and documentation, along with a completed application.

- Hold a current active license in good standing to practice dental hygiene in New Mexico
- Successful completion of an approved educational program in local anesthesia of at least 24 didactic hours and 10 hours of clinical training given in an accredited dental hygiene program (official transcripts must be sent directly to the board office from the university)
- Successfully pass a written and clinical local anesthesia examination administered by the **Western Regional Examination Board (WREB)**; the results of the WREB exam are valid in New Mexico for a period not to exceed five years (copy of certificate or score card)
- Submit a copy of current Basic Life Support (BLS) or Cardiac Pulmonary Resuscitation (CPR) certification accepted by the American Heart Association, Red Cross or the American Safety Health Institute; cannot be a self-study course.

REQUIREMENTS FOR LOCAL ANESTHESIA CERTIFICATION BY CREDENTIALS

For certification in local anesthesia by credentials you must possess the following qualifications and submit the required fees and documentation, along with a completed application.

- Hold a current active license in good standing to practice dental hygiene in New Mexico
- Successful completion of educational coursework in local anesthesia
- Submit a copy of current Basic Life Support (BLS) or Cardiac Pulmonary Resuscitation (CPR) certification accepted by the American Heart Association, Red Cross or the American Safety Health Institute; cannot be a self-study course
- Proof of administration of local anesthesia while engaged in the practice of dental hygiene in at least three of the past five years consecutive years (A notarized letter from the previous employer)
- A letter of verification from each state where the applicant holds a certificate for administering local anesthesia, sent directly from the state board, (state seal must be embossed)
- If applying for Local Anesthesia Certification by Credentials you **MUST** submit a signed Affidavit of Local Anesthesia Administration for administration of Local Anesthesia under General Supervision. (affidavit is attached to application)



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DENTAL HYGIENE
LOCAL ANESTHESIA CERTIFICATION APPLICATION

All licensing information provided is public information

(Application fees are non-refundable) (note: when submitting a check as payment, you are authorizing the State of New Mexico to process as a one-time electronic fund transfer or a check transaction)

Check if you are applying for:

- () Certificate by Examination APP. FEE \$40
() Certificate by Credentials APP. FEE \$100

1. PERSONAL INFORMATION

Last Name First Middle

Type or print your name as desired on official license or certificate

(Mailing Address) (City) (State) (Zip)

Contact Phone: Business Phone :

E-Mail Address:

Date of Birth

Place of Birth

Social Security Number

Proposed Practice Name:

Proposed Practice Address:

2. LICENSURE INFORMATION

List all jurisdictions in which you have or have held local anesthesia certification regardless of current status (attach additional pages if necessary):

Table with 6 columns: State/Country, Licensed by Exam/Credentials, License Number, First Initial Issue Date, License Status, Expiration Date

3. LOCAL ANESTHESIA EDUCATION: Dental Hygiene Program where you received anesthesia training.

School Granting Dental Hygiene Diploma (must be CODA accredited) City/State Date of Degree

4. Proof of Current BLS (Basic Life Support) or Cardiac Pulmonary Resuscitation (CPR):

(Title) (Date) (Location)

5. EXAMINATION

Date of WREB Anesthesia Examination: _____

Date and name of any other clinical practice examination:

**6. PLEASE ANSWER THE FOLLOWING QUESTIONS:
GIVE DETAILS OF ANY "YES" ANSWERS ON A SEPARATE SHEET OF PAPER**

A. Have you ever used another name under which records relating to your application, education, training or experience may be filed? YES _____ NO _____

If yes, please enter name(s) used: _____

B. Have you ever received a deferred prosecution or judgment or been convicted of, or pled guilty or nolo contendere to a felony or misdemeanor (not including traffic violations) in any state, territory or district of the United States or a foreign country? YES _____ NO _____

C. Have you ever had any disciplinary action taken against your dental hygiene license or any other professional license in any state? (NOTE: Disciplinary action includes, but is not limited to, suspension, probation, practice limitations, reprimand, letter or admonition, censure, and any allegations currently pending.) YES _____ NO _____

D. Have you ever been a defendant in a legal action involving professional liability (malpractice), or had a professional liability claim paid in your behalf, or paid such a claim yourself? YES _____ NO _____

E. Have you ever voluntarily surrendered a license or certification to practice dental hygiene or any other health related profession in any state, foreign country, territory, or institution? YES _____ NO _____

F. Are you currently more than thirty days in arrears in payment of amounts required to be paid pursuant to an outstanding judgment and order for child support in New Mexico or any other state? YES _____ NO _____

G. Do you have any medical condition that in any way limits, impairs or alters your ability to practice dental hygiene with reasonable skill and safety? YES _____ NO _____

H. Do you take medications or chemical substances that limits, impairs or alters, in any way, your ability to practice dental hygiene? YES _____ NO _____

*****If answered yes to questions (G) or (H) please answer questions (I) and (J)*****

I. Are the limitations or impairments caused by your medical condition reduced or ameliorated because you receive ongoing treatment (with or without medications) or participate in a monitoring program? YES _____ NO _____

J. Are the limitations or impairments caused by your medical condition reduced or ameliorated because of the field of practice, the setting or the manner in which you have chosen to practice? YES _____ NO _____

K. Have you ever been convicted of a crime of moral turpitude? YES _____ NO _____

L. Are you currently engaged in the illegal use of controlled and/or dangerous substances? YES _____ NO _____

M. Are you currently participating in a supervised rehabilitation program or professional assistance program which monitors you in order to assure that you are not engaging in the illegal use of controlled dangerous substances? YES _____ NO _____

N. Have you ever been licensed in New Mexico? YES _____ NO _____
If yes, what was your license number? _____ Issue date: _____
Expiration date: _____

LOCATION AND OCCUPATION FOR THE PAST THREE (3) YEARS:

Dates	City & State of residence	Occupation

I HEREBY CERTIFY that I am the person described and identified in this application; this application contains no willful misrepresentation; and the information given by me is true and complete to the best of my knowledge and belief.

I understand that all dental personnel who administer local anesthesia shall maintain current basic life support certification accepted by the American Heart Association, American Red Cross or the American Safety Health Institute.

I further certify I have read the New Mexico Dental Health Care Act and Rules and fully understand that I bind myself to be governed by them.

Signature of Applicant

Date

STATE OF _____

COUNTY OF _____

BEFORE ME on this _____ day of _____, 2____, personally appeared the above-named applicant who, being by my duly sworn upon oath, states that all statements and answers contained in this application are true and correct.

Notary Public

Seal

My Commission Expires: _____

All requested information is essential and must be provided. Failure to present a completed application by omitting information sought, having less than a full and complete disclosure, or failure to have the required documentation provided as required in this application, will result in delay or cause return of the application. The board shall neither approve nor deny an application until it is received in proper form, contains the information required by law and as requested by this application. The responsibility for completing the application is solely that of the applicant. The burden of proof in satisfying the Board that you are entitled to a license to administer local anesthesia is upon you.

THE BOARD DOES NOT HAVE THE AUTHORITY TO GRANT A WAIVER OF ANY REQUIREMENT.

IF THIS APPLICATION IS INCOMPLETE UPON ONE (1) YEAR OF RECEIPT, THE APPLICATION AND SUPPORTING DOCUMENTATION WILL BECOME NULL AND VOID.

Application fee payment method: ___ Check ___ Money Order ___ Credit Card Type: ___MC ___ Visa
Credit Card #: _____ Expiration date: _____ Amount \$ _____

NEW MEXICO BOARD OF DENTAL HEALTH CARE

AFFIDAVIT OF LOCAL ANESTHESIA ADMINISTRATION

(Certification by Credentials - ONLY)

Name of Dental Hygienist: _____

License #: _____

I _____, New Mexico licensed dentist, License # _____,
(please print your name)

hereby certify that the dental hygienist listed above has administered local anesthesia under my indirect supervision for a period of not less than two (2) years, and has been observed administering local anesthesia in at least twenty (20) cases/patients over that time. I further certify that the applicant is proficient and qualified to administer local anesthesia under the general supervision of a dentist and that the dental hygienist has demonstrated the ability to handle possible emergencies and side effects of local anesthesia administration, in accordance with the guidelines and rules of the New Mexico Board of Dental Health Care. I have personally evaluated this candidate to ensure the criteria provided by the New Mexico Board of Dental Health Care have been met. I find this candidate acceptable for certification to administer local anesthesia under general supervision.

SIGNED: _____

DATE: _____

RETURN COMPLETED AFFIDAVIT TO:

NEW MEXICO BOARD OF DENTAL HEALTH CARE
P.O. BOX 25101
SANTA FE, NM 87505

Office Use Only:	
Board Delegate	
Date	