

OFFICE OF PROFESSIONAL LICENSURE AND CERTIFICATION
STATE OF NEW HAMPSHIRE
DIVISION OF HEALTH PROFESSIONS
Board of Dental Examiners
7 Eagle Square
Concord, N.H. 03301
Telephone 603-271-4561 · Fax 603-271-6702

LINDSEY B. COURTNEY
Executive Director



APPLICATION FOR CPHDH
(CERTIFIED PUBLIC HEALTH DENTAL HYGIENIST)
CERTIFICATION

APPLICATION FEE

A check or money order in the amount of **\$25.00**, made payable to the “**TREASURER, STATE OF NEW HAMPSHIRE**” must accompany the application. If presented in person, the payment may be made in cash.

REQUIREMENTS FOR APPLICATION

In addition to the application form, the following documents shall be filed with the Board:

- Proof of acceptable dental hygienist experience and CPHDH course completion. Courses must comply with administrative rule Den 302.07 (a) and (b).
- Effective April 1, 2016, proof of current BLS-HCP.
- Proof of an approved course in infection control.
- A letter confirming there is a collaborative agreement signed by the supervising dentist.
- Passport photo.
- Please mail the application, fee and documents to the Board’s office.

RENEWAL

CPHDHs shall renew their CPHDH certification in odd-numbered years before May 1st, if CPHDH employment is continued.

**NEW HAMPSHIRE BOARD OF DENTAL EXAMINERS
APPLICATION FOR CERTIFICATION
AS A CERTIFIED PUBLIC HEALTH DENTAL HYGIENIST**

FOR OFFICE USE ONLY PAID \$ _____ CASH, CHECK OR MO # _____

PRINT OR TYPE

1. Name in Full (first, middle, last) _____
2. Date of Birth (month, day, year) _____
3. Place of Birth (city, county, state) _____
4. Social Security Number _____
5. Have you ever been known by any other name? _____ yes _____ no
If yes, give other name(s) _____
6. Home address: _____
Home Telephone: _____
Work address: _____
Work telephone: _____
Primary Email address (either business or personal) _____
7. Name of Supervising Dentist: _____
8. Are you currently certified in CPR? Yes _____ No _____ (Please attach proof.)
(Effective April 1, 2016, applicants shall be certified in BLS-HCP.)
9. Please check your level of education:
_____ Master's Degree in Public Health
_____ Bachelor's Degree in dental hygiene, with a minimum of 6 hours in community dental health
_____ Registered Dental Hygienist (without either a Master's Degree in Public Health or Bachelor's Degree in dental hygiene).

You must submit original transcripts for your Master's Degree in Public Health and/or Bachelor's Degree in dental hygiene, which show compliance with course requirements as set forth in New Hampshire administrative rule Den 302.07 (a). If a transcript is not available, you shall submit certificates of completion for those courses required by Den 302.07 (a). Registered Dental Hygienists shall submit certificates of completion for those courses required by Den 302.07 (a) and (b).

Proof of education:

I have completed the following requirements:

- ___ Practiced as a dental hygienist for 3200 hours, 1600 hours of which shall be within the 2 years prior to certification;
- ___ Completed a course in caries stabilization that is a minimum of 6 hours as outlined in Den 302.07 (a)(3)(a);
- ___ Qualified in dental sealants pursuant to Den 302.05 (l) and (m), if similar training was not received as part of the dental hygiene school curriculum.
- ___ Completed an approved course in infection control as outlined in Den 302.07 (a)(3)(c).

You must submit proof of the listed items above.

The following affidavit must be completed by the applicant after the previous portion is filled out.

STATEMENT BY APPLICANT
(Must be sworn to before a notary public)

I understand that by signing this application I am:

1. Waiving any confidentiality regarding disclosure to the Board from any other jurisdiction about any pending complaints or action being taken against my license to practice as a certified public health dental hygienist.
2. Giving consent for a criminal background check.

I, _____,
of full age, under the penalties for falsification pursuant to RSA 641:1 through RSA 641:3, state that I am
the person referred to in the foregoing application, that I have carefully read the instructions given and
questions asked in the application form, and that all statements made therein are true and correct as of this

_____ of _____, 20 ____ .
(day) (month)

Signature of Applicant

Attach passport photo here

Sworn to before me and subscribed in my presence

on this _____ day of _____, 20 ____

Signature

Printed name

my commission expires: _____

TO BE COMPLETED BY THE BOARD OF DENTAL EXAMINERS

Certificate number: _____ Issued: _____

Approved by: _____