



DEPARTAMENTO DE

SALUD

GOBIERNO DE PUERTO RICO

SECRETARÍA AUXILIAR PARA LA REGULACIÓN
DE LA SALUD PÚBLICA

División de Licenciamiento de Médicos y
Profesionales de la Salud

Junta Dental Examinadora

**APPLICATION FOR EXAMINATION AND LICENSE TO PRACTICE THE
PROFESSION OF DENTAL HYGIENIST**

AFFIDAVIT



Full Name of Applicant

Social Security Number XXX-XX _____ and identified by

Type of Identification

Number

AND DULY SWORN -----

States that he/she is the person referred to in this application, and that the statements contained herein are true in every respect; that the attached photograph is a true likeness of him/herself and was taken within the last six (6) months.

Acknowledges that any false statement in this application or by way of attachment shall be sufficient grounds for the **PUERTO RICO DENTAL BOARD OF EXAMINERS** to deny said license, or to revoke a license after it has been granted, or to penalize a person for incurring in a false statement.

Authorizes the **PUERTO RICO DENTAL BOARD OF EXAMINERS** or any other person, employer, corporation, Institution, agency, or public or private entity, to exchange any information required about his/her person or about his/her license status, as well as for expanding, clarifying or checking information offered in this application or by way of attachment.

Applicant's signature

Sworn and subscribed BEFORE ME, on this _____ day of _____, _____,
in _____.

AFFIDAVIT NO: _____

NOTARY'S SEAL

Notary's Signature

NAME OF APPLICANT: _____
Paternal Surname Maternal Surname Name MII

PERMANENT ADDRESS: _____
No. and Street Community or Housing Development Town ZipCode

POSTAL ADDRESS: _____

TELEPHONES: RES. _____ **CELLULAR:** _____ **EMAIL:** _____

PHYSICAL DESCRIPTION OF APPLICANT

HEIGHT: _____ COLOR OF HAIR: _____ COLOR OF EYES: _____ WEIGHT: _____

ANY PARTICULAR FEATURE: _____

APPLICANT'S PERSONAL DATA

DATE OF BIRTH: _____ PLACE: _____
Month / Day / Year City State or Country

ARE YOU A CITIZEN OF THE UNITED STATES? _____ If your answer is No, indicate if you are:
_____ NATURALIZED _____ or _____ RESIDENT _____
Certificate Number Card Number

HAVE YOU EVER CHANGED YOUR NAME OR LAST NAME? _____ If your answer is Yes, indicate:
_____/_____
Date and Place of Change Reason for Change Original Name and/or Last Name

HAVE YOU BEEN CONVICTED OF ANY CRIME? _____ If your answer is Yes, indicate:
_____/_____
Nature of Crime Place and Date Status

PLEASE ATTACH DOCUMENT(S) PROVIDING ADDITIONAL INFORMATION IF NEEDED.

HAVE YOU SUFFERED OR ARE SUFFERING FROM ANY CONTAGIOUS DISEASE OR CONDITION? _____
If your answer is Yes, submit a medical certificate explaining the disease and its status on filing date of application.

CERTIFICATE OF GOOD MORAL CONDUCT

We, the undersigned, CERTIFY, before the BOARD OF EXAMINERS OF DENTISTRY, that we personally know
_____ and can attest to his/her being a responsible and serious person with a good moral
Name of Applicant
character, whereby we consider the applicant as fit for the practice of the profession of DENTAL HYGIENIST.

Name in print

Address

Signature

Name in print

Address

Signature

ACADEMIC BACKGROUND

High School	Place	Date of graduation
Dental Hygienist course (institution)	Place	Date of graduation

REQUIREMENTS FOR THE PRACTICE OF THE PROFESSION OF DENTAL HYGIENIST IN PUERTO RICO

Pursuant to Public Law Number 75 of August 1925, as amended by Public Law Number 74 of June 1971, and the Regulation of the Board of Examiners of Dentistry, the candidate for examination and license as Dental Hygienist must comply with the following requirements and provide evidence.

1. To be eighteen years old.
2. To be an American citizen or a legal resident of Puerto Rico.
3. To be in possession of a good moral standing.
4. To have graduated from a high school accredited by the Department of Education, or to be in possession of an equivalent degree.
5. To have approved a Dental Hygienist course from a school, college or institution accredited by the Department of Education, or from an accredited school, college, or institution in the United States.

THE APPLICANT MUST ACCOMPANY APPLICATION FORM WITH THE FOLLOWING DOCUMENTS:

- ____ 1. Application completed in all its parts, sworn before notary public and with your photograph adhered on the space provided.
- ____ 2. **Birth certificate (original and a copy).** If you were born in PR, your birth certificate should be issued later than July 2010. **Foreign applicants must provide a Resident Card or Naturalization Certificate number and show whichever documents for the purpose of verification.**
- ____ 3. **Criminal Record Certificate** issued by the Police Department of Puerto Rico within a month term (30 days) prior to the filing date of application.
- ____ 4. **Original and copy of high school diploma or certificate.** The original shall be returned to the applicant after copy verification. **In case the diploma or certificate is not available, an original official school transcript may substitute for the missing diploma or certificate.**
- ____ 5. **Official Transcripts and Graduation Certificate (letter of completion) from the Dental Hygienist course.** These documents are to be sent directly from the institution to the office of the Board.
- ____ 6. **Money Order** for ten dollars (\$10.00), payable to the Secretary of the Treasury of Puerto Rico.

Physical address:

#1590 GM Group Plaza Building,
Ponce de León Street, San Juan, Puerto Rico. 00908 3rd Floor

Postal Address:

PUERTO RICO DENTAL BOARD OF EXAMINERS
P. O. BOX 10200
SAN JUAN, P.R. 00908-0200
Telephone: (787) 787-765-2929 X 6605
Email: cindy.reyes@salud.pr.gov

To visit our office, please use the information below:

For appointments:

Link: <https://profesionalesdelasalud.turnospr.com/>



To access our portal:

Link <https://www.salud.pr.gov/cms/444>



GENERAL INFORMATION

- 1. INFORMATION BOOKLET:** Applicants must make sure to obtain the **INFORMATION HANDBOOK FOR THE PRACTICE OF THE PROFESSION OF DENTAL HYGIENIST**, available at the office of the Board for the amount of five dollars (\$5.00). This amount may be included in the payment of examination and license fees.
- 2. THEORETICAL EXAMINATION:** The Board of Examiners of Dentistry utilizes the theoretical examinations of the National Board of Dental Examinations of the American Dental Association (NATIONAL BOARDS) as the Theoretical Component of the licensing examination. These examinations must have been approved within a five (5) year term prior to the date of application.

Applicants must present a performance report. This document must be sent directly from the National Board to the office of the Board of Examiners of Dentistry.

- 3. CLINICAL EXAMINATION:** The Board makes use of the clinical examinations of the Council of Interstate Testing Agencies (CITA) as the Clinical Component of the licensing examination.

Those applicants who have approved said examinations must present a performance report. This document must be sent directly from the Council of Interstate Testing Agencies (CITA) to the office of the Board of Examiners of Dentistry.

- 4. No application shall be considered until the applicant has filed all the documents accrediting his/her compliance with all requirements, as listed in this document.** Check the press in order to learn about call dates, or request information at the office of the Board of Examiners of Dentistry.

ASSESSMENT CHECKLIST – ONLY FOR THE EXCLUSIVE USE OF THE BOARD

APPLICATION DATE OF RECEIPT: _____

THIS APPLICATION HAS BEEN:

_____ **APPROVED FOR EXAMINATION**

President

Member

Member

Member

Date of Assessment

_____ **DENIED**

President

Member

Member

Member

REASON: _____

Exam Approval Date	Issued License Number	Date of License
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