NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Application Information for EXPANDED SCOPE FUNCTIONS

Application Fee: The application fee to add the following expanded functions to your dental assistant or dental hygienist license is $10.00 per application ($10 for each time you add an expanded scope function to your current license). **Pay by check/money order (your cancelled check is your proof of receipt).**

☐ Interim Therapeutic Restorations
☐ Write Prescriptions for Mouth Rinses and Fluoride Products
☐ Monitor, Administration and Titrate Nitrous Oxide
☐ Make Minor Denture Adjustments (Only for holders of a Public Health Authorization for treating children and adults)

Application Section A – Personal Information

1. ☐ Name, address, and Nebraska Dental Hygiene License number.

Application Section B – Completion of Approved Course (Provide copy of the following document)

1. ☐ Name and location of institution providing the expanded scope function course;

2. ☐ Date of successful completion of the expanded scope function course;

Please note that an approved course needs to be provided by a Commission on Dental Accreditation (CODA) accredited dental hygiene or dental assisting program.

Application Section C – Attestation

All applicants are required to complete this section.

OTHER INFORMATION:

Any documents written in a language other than English must be accompanied by a complete translation into the English language. The translation must be an original document and contain the notarized signature of the translator. An individual may not translate his/her own documents.

Application Processing: All application will be processed in date order received. If a preliminary review shows that you are missing information, you will be contacted **by e-mail** within approximately 15 days**.**

TIME FRAME FOR PROCESSING:

Certificate Decision: 8-10 weeks from receipt of a complete application

Please note:

1. You have 90 days to complete an application. If your application is not completed after 90 days, your application and all supporting documents will be destroyed and a refund will be processed, less a $25 administrative fee.
2. If an individual other than the applicant pays the application fee, refunds will be issued to that individual and their social security number will be required to process the refund.
3. If a business entity will be paying the application fee, refunds will be issued to that business entity and a copy of their W-9 is required to process the refund.

Contact Information: Licensure Unit, 301 Centennial Mall South, PO Box 94986, Lincoln NE 68509-4986
Telephone: 402-471-2118 / FAX: 402-742-8355 / E-Mail: dhhs.medicaloffice@nebraska.gov

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BU # 25550143
License #

Division of Public Health /Licensure Unit
P.O. Box 94986, Lincoln, Nebraska 68509-4986

APPLICATION FEE: $10.00 – for each time you add an expanded scope function(s) to your current license

NEBRASKA Application for Expanded Scope Functions for Dental Hygienists

☐ Interim Therapeutic Restorations
☐ Write Prescriptions for Mouth Rinses and Fluoride Products
☐ Monitor, Administration and Titrate Nitrous Oxide
☐ Make Minor Denture Adjustments (Only for holders of a Public Health Authorization for treating children and adults)

SECTION A – Personal Information

Name:			
Address:			
	City:	State:	Zip:
Nebraska Dental Hygiene License Number:			
☐ I also hold a Public Health Authorization for Treating Children		☐ I hold a Public Health Authorization for Treating Children and Adults	

SECTION B - COMPLETION OF APPROVED COURSE (A copy of proof of successful completion of approved course is required)

Name and location of the accredited dental hygiene or dental assistant program providing the course that you have successfully completed:		
Date of successful completion of course: (If course was completed outside the State of Nebraska, please attach a course syllabus.)		
Have you actively practiced in Nebraska performing any of the expanded functions listed above prior to this application?	YES ☐	NO ☐
If yes, how many days have you practiced in Nebraska performing any of the expanded functions listed above?	Number of days:	

SECTION C - ATTESTATION

Application Attestation and Signature: I attest that:
1. I have read the application or have had the application read to me; and
2. All statements on this application are true and complete.

Print Name: _____

Signature: _____ Date: _____

Contact Information:
Telephone: 402-471-2118
Email: DHHS.medicaloffice@nebraska.gov

Mailing Address:
DHHS, Division of Public Health
Licensure Unit – 1st Floor
P.O. Box 94986
Lincoln, Nebraska 68509-4986

Physical Address:
DHHS, Division of Public Health
Licensure Unit- 1st Floor
301 Centennial Mall South,
Lincoln. Nebraska 68508