**KANSAS DENTAL BOARD**
**900 SW Jackson, Room 564-S**
**Topeka, KS 66612**
**Phone (785) 296-6400 Fax (785) 296-3116**

Permit Number
_____

**DENTAL HYGIENE EXTENDED CARE PERMIT I and II APPLICATION**
An Extended Care Permit II includes the Permit I requirements

**Application Date:** _____

**Permit Requested:** ☐**Extended Care Permit I**
☐**Extended Care Permit II**

**Licensed Dental Hygienist:**

_____
(Print Name) (License #)

_____
(Home Address) (Telephone #)

_____
(City) (State) (Zip Code)

**Licensed Sponsoring Dentist:**

_____
(Print Name) (License #)

_____
(Office Address) (Telephone #)

_____
(City) (State) (Zip Code)

**Professional Liability Insurance:** _____
(Carrier and Policy #)

**List practice location(s) and hours worked (1200 hrs for ECP I or 1800 hrs. for ECP II in previous 3 years required) Also required if returning from a period of retirement or disability, see below.**

Practice Name: _____ number of hours worked in last 3 years: _____
Street Address: _____
City, State, Zip _____
Phone Number: _____

Practice Name: _____ number of hours worked in last 3 years: _____
Street Address: _____
City, State, Zip _____
Phone Number: _____

Practice Name: _____ number of hours worked in last 3 years: _____
Street Address: _____
City, State, Zip _____ Total _____
Phone Number: _____ ECP I (1200) or ECP II (1800)

**or**

Teaching location(s) during prior three years (2 academic years in previous three years required)
Accredited Hygiene Program Name:
Street Address: _____ Dates employed: _____
City, State, Zip _____
Phone Number: _____

Accredited Hygiene Program Name:
Street Address: _____ Dates employed: _____
City, State, Zip _____
Phone Number: _____

**DENTAL HYGIENE EXTENDED CARE PERMIT I and II APPLICATION**

**If you have not practiced or taught for the last 3 years:**

☐ (check here) If you have completed the practice hours requirements of 1200 hrs or 1800 hrs prior to a period of retirement or disability, but not within the past three years, and you are returning to active practice after such period or you have retained a license to practice but have not practiced in the past 3 or more years you may either complete a **refresher course** approved by the board under K.A.R. 71-3-8. (attach certificate)

**or**

☐ (check here). If you have **performed 200 hours of dental hygiene care within the last 12 months** under the supervision of dentists licensed in the state of Kansas. Provide a letter of endorsement from one or more of your supervising dentists. The dentist(s) must verify 200 hours of practice in the last year. (attach letters.)
(You must list the practice locations above for the 1200 or 1800 hours of required practice, prior to your period of disability or retirement or inactive period.)

********** For Extended Care Permit II **********

**Special Needs Care Hours:** ____ (6 hours required now and in each renewal) List and attach certificates or evidence

**For Extended Care Permit II Only**

| Date | Special needs Course Title | Clinician | Sponsor | Credit Hours |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | **Total Hours** | |

*I have agreed to sponsor the above named dental hygienist in accordance with K.S.A. 65-1456 as amended:*

**Signature of Sponsoring Dentist:** _____ **DATE:** _____

*I attest that all statements on this form are true and that I will work in accordance with K.S.A. 65-1456 as amended:*

**Signature of Hygienist Applicant:** _____ **DATE:** _____

**Once your application has been approved, you will be issued a new card with your ECP designation. Enclose a check or money order payable to: KANSAS DENTAL BOARD for $5.00 for the cost of the card.**

**Send application, attachments and $5.00 check or money order to:**

**KANSAS DENTAL BOARD**
**900 SW Jackson, Room 564-S**
**Topeka, KS 66612**

**Office use only** _____

_____ _____

**Approved by KDB Executive Director** **Date**