

VIRGINIA BOARD OF DENTISTRY
BOARD LICENSING WORKGROUP AGENDA
AUGUST 22, 2025

TIME

9:30 a.m.	Call to Order – Sultan E. Chaudhry, D.D.S., President	--
	Introduction of Committee Members, Staff, and Guests – Ms. Sacksteder	--
9:40 a.m.	Public Comment – Dr. Chaudhry	--
	• May 22, 2025, Email from Abdur R. Chaudhry, R.D.H.	1-2
	Legislation and Regulation – Erin Barrett	
	• Senate Bill 1475	3-5
	Presentation – HWDC – Dr. Yetty Shobo	
	• 2025 Dentist and Dental Hygienist Workforce Survey	6-40
	Committee Discussion Topics – Ms. Sacksteder	41
	• Credentialing	42-43
	○ Topic Questions for Credentialing	44-51
	○ Licensure Requirements by State	52
	○ Board of Medicine change in regulations	53-54
	○ Dentist – Current Laws and Regulations	55-56
	○ Dentist – Map of Active Practice Requirements	57-58
	○ DH – Current Laws and Regulations	59-61
	○ DH – Map of Active Practice Requirements	62
	• Additional Resources for Consideration	63-64
	○ ADHA Position Statements	65-79
	○ Standards of DH Clinical Practice	80-83
	○ Curriculum of BS in Dental Hygiene	84-87
	○ New ADA Policies	88-89
	○ ADHA Objection	90-92
	○ Legislation allows Foreign-Trained Dentist	93-102
	○ 2023 BOD Licensure Workgroup Report	103
	• Internationally Trained Dentist	104
	○ State Requirements for Internationally Trained Dentist to become DH	105-106
	○ Topic Questions for Internationally Trained Dentist to become DH	105-106
	Decision – Ms. Sacksteder	--
	Adjourn	--

Moore, Sarah (DHP)

From: rauf yahya <raufyahya@gmail.com>
Sent: Thursday, May 22, 2025 3:08 PM
To: Moore, Sarah (DHP); Board of Dentistry
Subject: SB1475

Attention: VA Board of dentistry

My name is Abdur R Chaudry, RDH and I oppose the passage of SB1475. I want to let u know my personal experience. I started working in a dental office from 2002 and I did not have any back ground of dentistry. the Dentist did not have any hygienist in his office either dentist would do the Prophies or deep cleaning. I never see them doing Periodontal maintenance or referring patients to the Periodontist. I decided to become a dental hygienist and went in school in 2012-2014. I graduated as a dental hygienist in 2014, then I realized that doing properly deep cleanings are not that easy, its needs a lot of training, skill and patience. We hygienist just work for Perio in our total of 2 years of program, we see variety of patients with Early Periodontist, Moderate, Severe, to advanced Periodontist.

We also study the co relation of gum disease with heart disease, diabetes, Alzheimer's disease, Pre mature baby, Osteoporosis, Pregnancy related gums disease, With in this kinds of study and advancement, I can not imagine that with all this new scientific base studies where , you can not get knee surgery, kidney transplant, or heart transplant in the presence of gums infections or teeth infections, instead of keeping the standard high for the sake of patients well being American Dental Associations is trying to lower the standard of care.

I personally managed a dental office and where I have helped several foreigners dentist for internship, trust me, they don't teach any thing about Perio disease in other courtiers, they even don't know how to Perio probing or diagnose proper Peri disease , treating is beyond their training scope from back home. Secondly, the Dental Hygiene is designed and invented by USA that's why, We have the best hygienist in the world, and this is pride of American dental hygiene organization. I worked in the office where multiple ethnicity patients comes from, Pakistan, Bangladesh, Afghanistan, India, and South American countries., These patients some times get their cleaning first time cleaning and results which the get after the proper deep cleaning are beyond their imaginations, some how they think if their gums bleed, swollen bad tats or mal odor is normal thing which can not be changed. I have treated so many patients where the patient does not want to open their mouth due to the sever gums disease but I would attach just one of my patient's before and after pictures and xrays for your board members review, then they can decide that if we want to give this kind of care to our patients then you need a kind of skill which we learn from dental hygiene schools. further I am copying the message on the behalf of our ADHA organization for your review:

The American Dental Hygienists' Association (ADHA®) opposes the passage of SB1475, a measure permitting alternative pathways for individuals seeking licensure as dental hygienists in Massachusetts. While this legislation aims to address workforce shortages, it compromises the professional standards and integrity of dental hygiene practice.

The ADHA opposes policies that allow individuals to obtain dental hygiene licensure through alternative pathways. Permitting individuals in complementary roles to practice dental hygiene without completing the same extensive education and clinical training is harmful to patients and undermines the profession's integrity.

SB1475 includes provisions for nontraditional pathways, such as allowing internationally trained dentists to pass a standardized board examination to obtain licensure without formal dental hygiene training. This bypasses the rigorous and comprehensive education provided by U.S. dental hygiene programs accredited by the Commission on Dental Accreditation (CODA). Dental hygiene education is specialized and distinct from other curricula, such as dentistry. These pathways fail to meet the critical standards necessary to ensure patient safety and uphold the integrity of dental hygiene practice.

The ADHA firmly believes that any individual seeking to practice dental hygiene in the U.S. must complete a CODA-accredited dental hygiene education program and meet the clinical training, examination, and practice requirements necessary to earn a dental hygiene license, without exception.

While the ADHA acknowledges and commends the collaborative efforts of the Massachusetts Dental Hygienists' Association to address workforce challenges and increase licensure standards, we maintain that formal dental hygiene education remains the only acceptable foundation for practicing dental hygiene.

At a time when workforce shortages challenge access to dental care, solutions must prioritize public safety, maintain professional standards, and focus on improving patient outcomes. Expanding eligibility for licensure without maintaining these standards is not the solution. The ADHA encourages dental hygienists and supporters to express their concerns regarding SB1475.

Sincerely,

Abdur R Chaudhry, RDH License # 0402206433

SB1475

- <https://lis.virginia.gov/bill-details/20251/SB1475>

2025 Regular Session

SB1475

Dentists & dental hygienists; work group to assess expedited pathways for licensure, report.

Status

Acts of Assembly Chapter

Patron

Introduced by: Todd E. Pillon (Chief Patron)

Summary As Passed Senate All Summaries

Board of Dentistry; expedited licensure. Directs the Board of Dentistry to convene a work group including the Virginia Dental Association and the Virginia Dental Hygienists' Association to assess expedited pathways for licensure for dentists and dental hygienists. The bill specifies that the work group shall (i) review the licensure by credentialing statutes governing dentists and the licensure statutes governing dental hygienists and make recommendations on how such statutes can be updated to reflect an expedited pathway for licensure and (ii) study options for and make recommendations on a pathway for qualified internationally trained dentists to practice dental hygiene under the supervision of a licensed dentist.

Bill Versions

Show All Versions

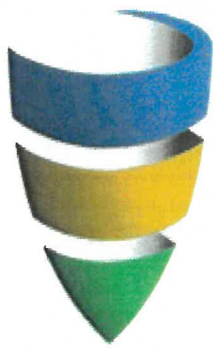
Senate	Chaptered	PDF
Senate	Education and Health Substitute Offered	PDF

History

1/17/2025	Senate	Presented and ordered printed 25103862D
1/17/2025	Senate	Referred to Committee on Education and Health
1/24/2025	Senate	Assigned Education sub: Health
1/30/2025	Senate	Reported from Education and Health with substitute (15-Y 0-N)
1/30/2025	Senate	Committee substitute printed 25105986D-S1
1/30/2025	Senate	Fiscal Impact Statement from Department of Planning and Budget (SB1475)
1/31/2025	Senate	Rules suspended
1/31/2025	Senate	Constitutional reading dispensed (on 1st reading) (39-Y 0-N)

1/31/2025	Senate	Passed by for the day
2/3/2025	Senate	Read second time
2/3/2025	Senate	Reading of substitute waived
2/3/2025	Senate	Education and Health Substitute agreed to
2/3/2025	Senate	Engrossed by Senate - committee substitute
2/3/2025	Senate	Rules suspended
2/3/2025	Senate	Constitutional reading dispensed (on 3rd reading)
2/3/2025	Senate	Passed Senate (40-Y 0-N)
2/6/2025	House	Placed on Calendar
2/6/2025	House	Read first time
2/6/2025	House	Referred to Committee on Health and Human Services
2/6/2025	House	Assigned sub: Health
2/11/2025	House	Subcommittee recommends reporting (8-Y 0-N)
2/13/2025	House	Reported from Health and Human Services (21-Y 0-N)
2/17/2025	House	Read second time
2/18/2025	House	Read third time
2/18/2025	House	Passed House (97-Y 0-N)
2/20/2025	Senate	Enrolled
2/20/2025	Senate	Bill text as passed Senate and House (SB1475ER)
2/20/2025	Senate	Fiscal Impact Statement from Department of Planning and Budget (SB1475)
2/20/2025	House	Signed by Speaker
2/23/2025	Senate	Signed by President
3/5/2025	Senate	Enrolled Bill Communicated to Governor on March 5, 2025
3/5/2025	Governor	Governor's Action Deadline 11:59 p.m., March 24, 2025
3/21/2025	Governor	Approved by Governor-Chapter 363 (Effective 07/01/25)
3/21/2025	Governor	Acts of Assembly Chapter text (CHAP0363)

Presentation of Workforce of Dentists and Dental Hygienists in Virginia -Yetty Shobo



Virginia Department of Health Professions



Virginia Dentist Workforce: 2024 Survey Findings

Yetty Shobo, PhD and Barbara Hodgdon, PhD
The Healthcare Workforce Data Center and Data
Analytics Division
Board of Dentistry Meeting
June 13th, 2025



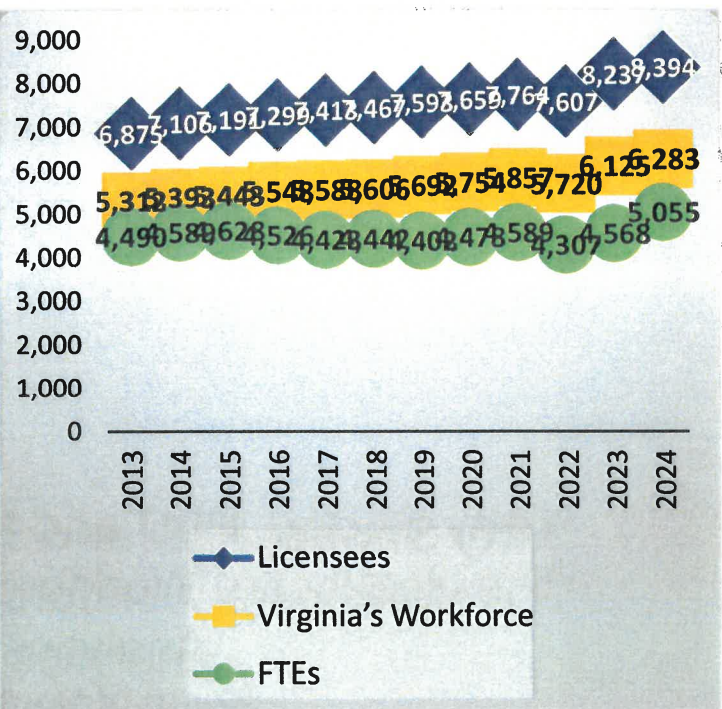
Trends in Dentistry Licensees and Workforce



Since 2013, 22%, 18%, and 13% increase in total licensees, workforce, and FTEs

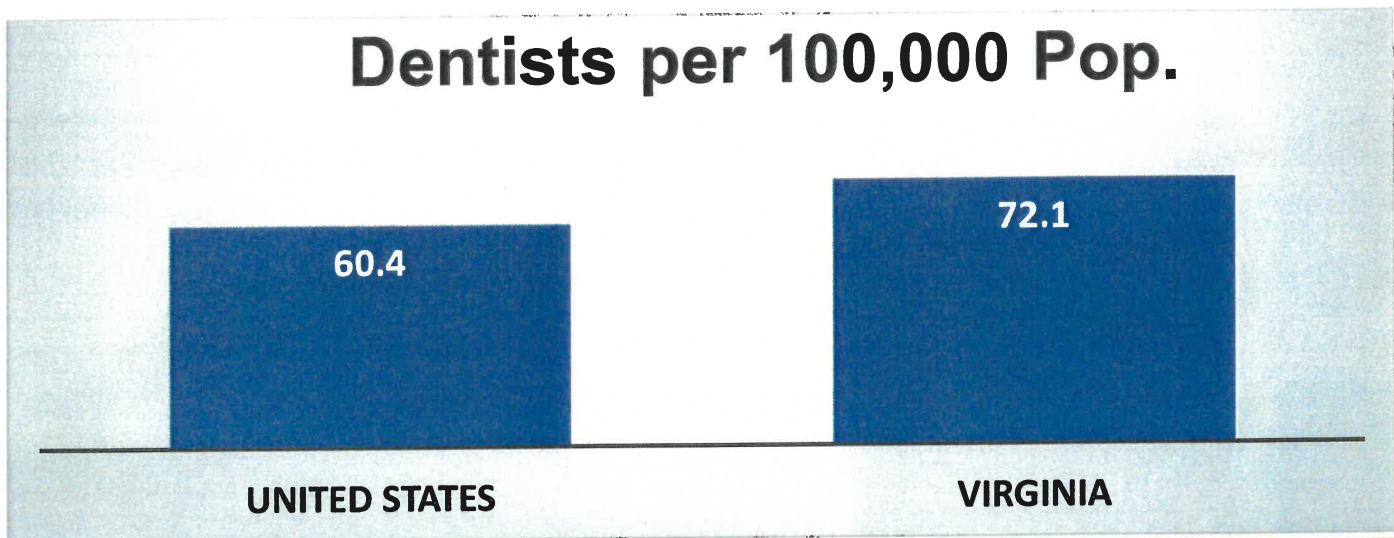


Licensees: 8,394
Workforce: 6,283
FTEs: 5,055





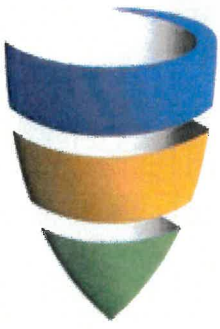
Dentists per 100,000 Pop.



Overall, VA dentistry workforce appears adequate relative to national numbers



6,283 dentists worked in VA in 2024; 3% of 202,304 nationally



Virginia Department of Health Professions



Trends in Demographics



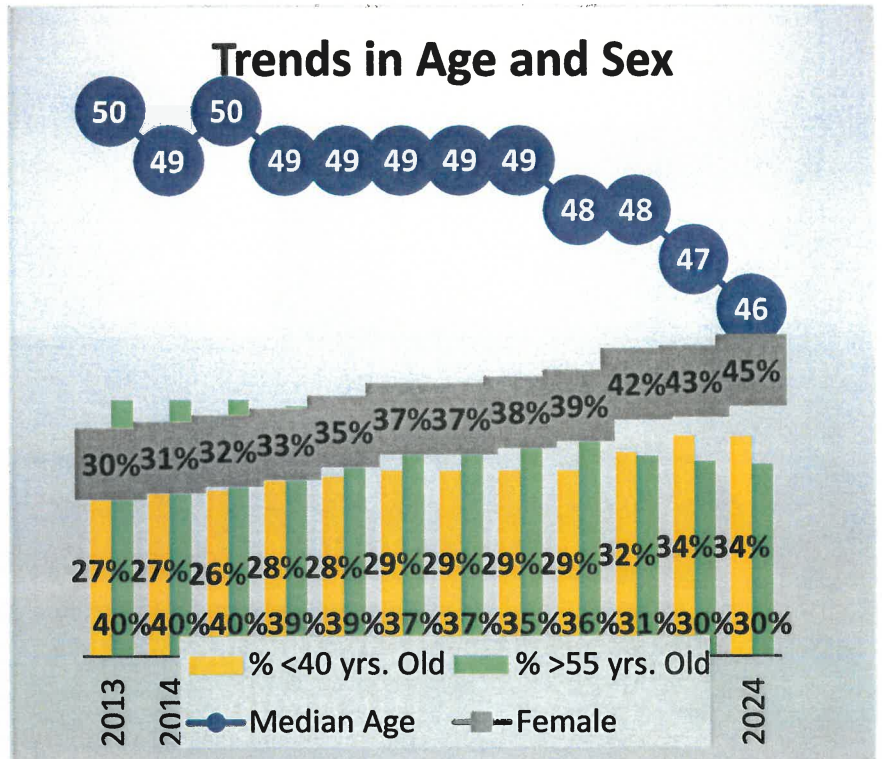
% Female increasing over time



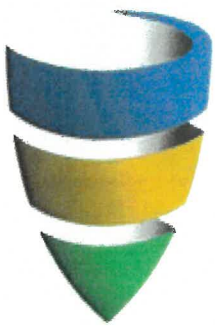
Median age decreasing



Increase in % under 40



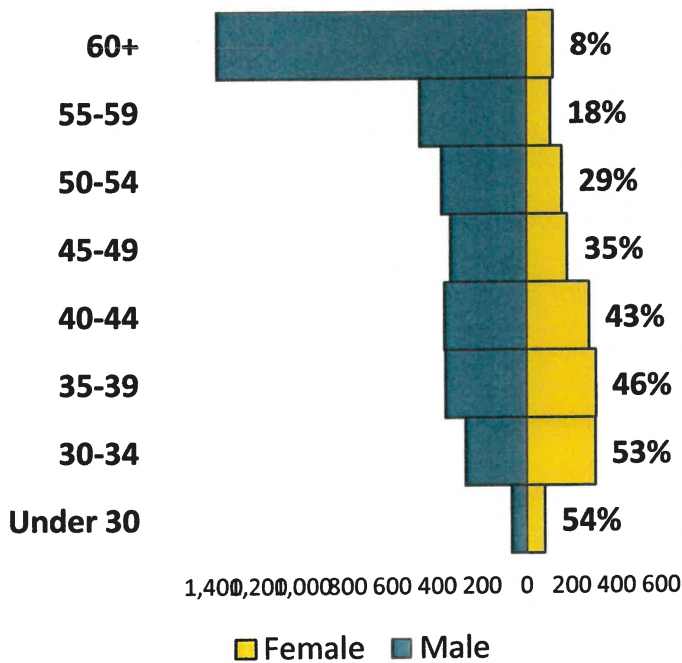
Used by permission of HWDC



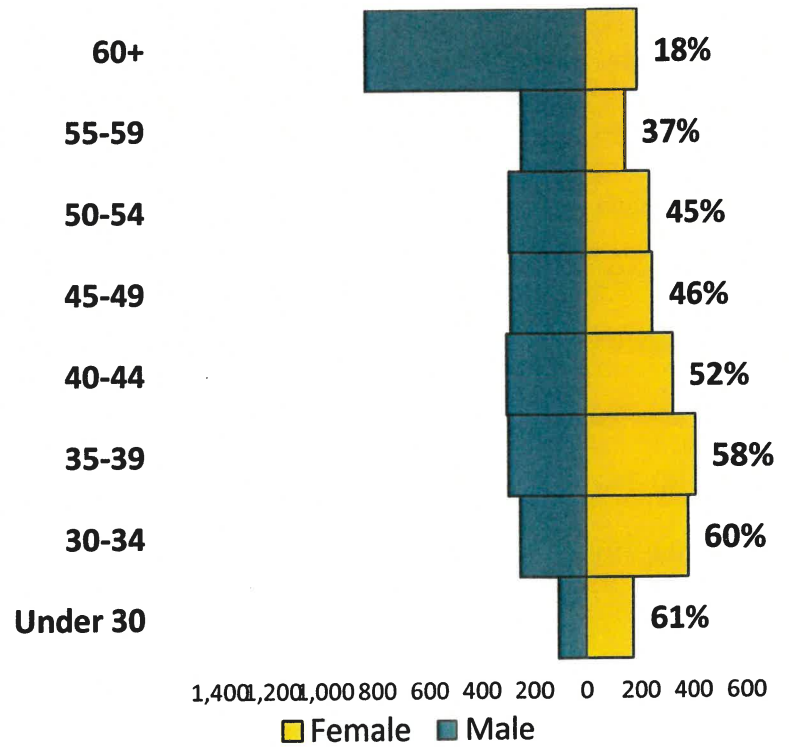
Virginia Department of Health Professions



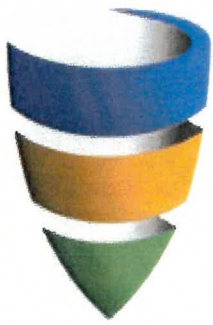
2013 Dentist Population Pyramid



2024 Dentist Population Pyramid



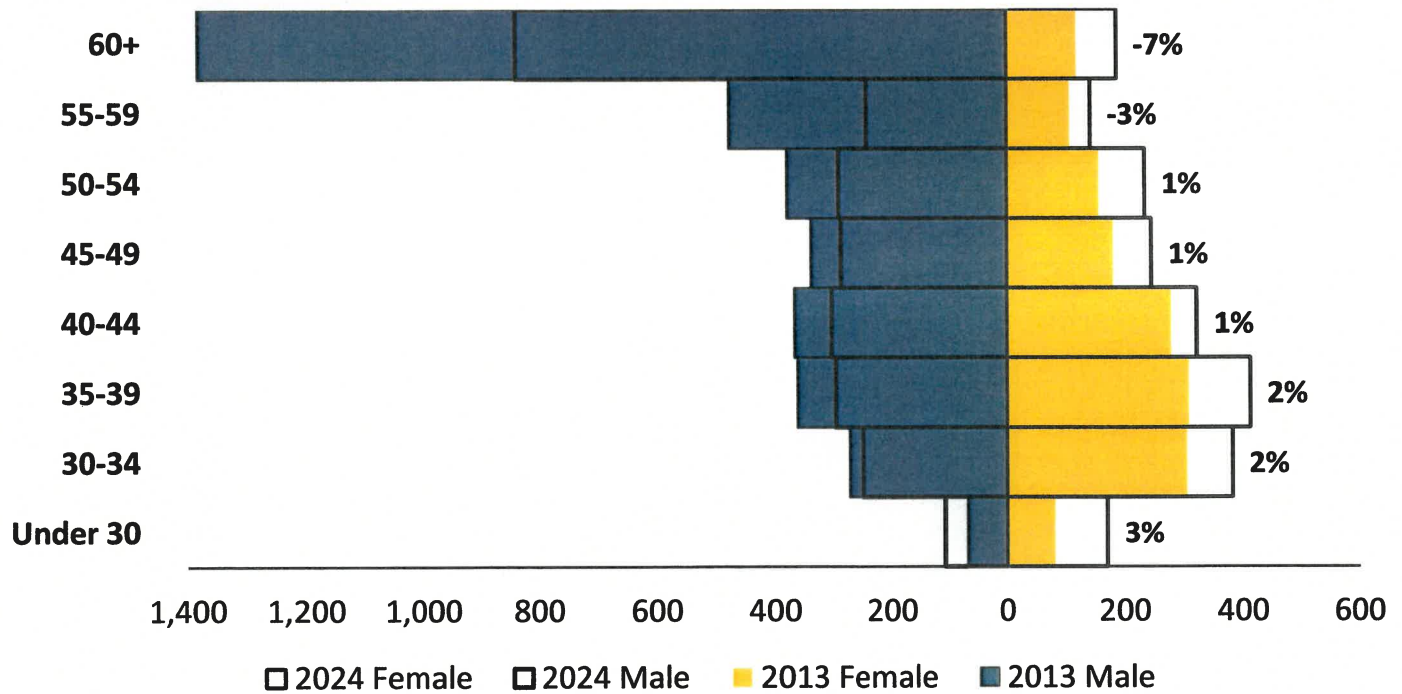
Used by permission of HWDC



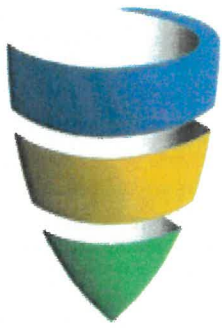
Virginia Department of Health Professions



2013 versus 2024 Dentist Population Pyramid



Used by permission of HWDC



Virginia Department of Health Professions



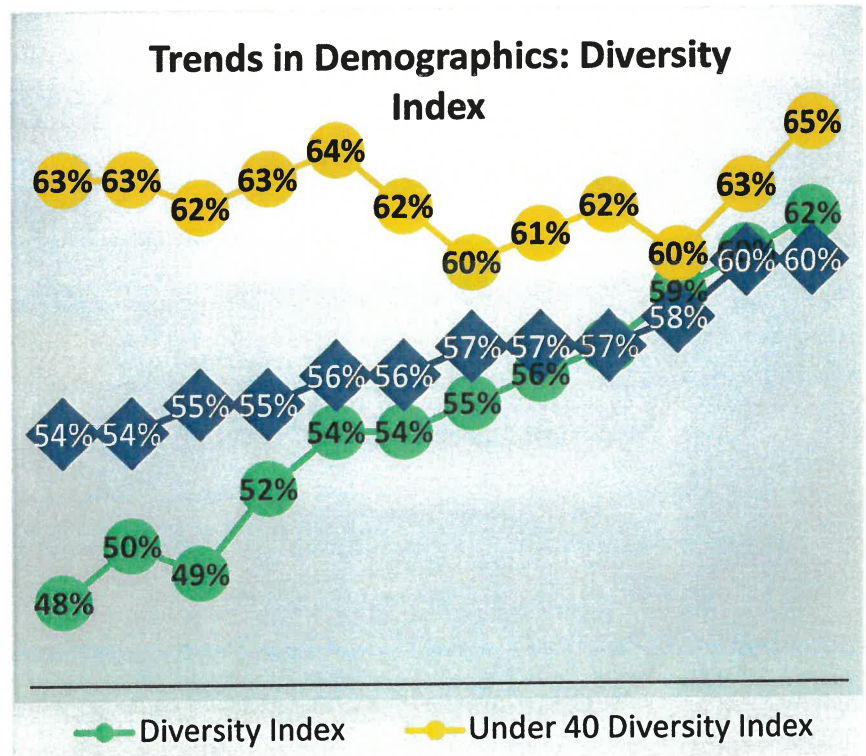
Trends in Demographics



Diversity index increasing over time



<40 diversity index higher than statewide diversity index



Used by permission of HWDC



Trends in Income and Debt: Dentists



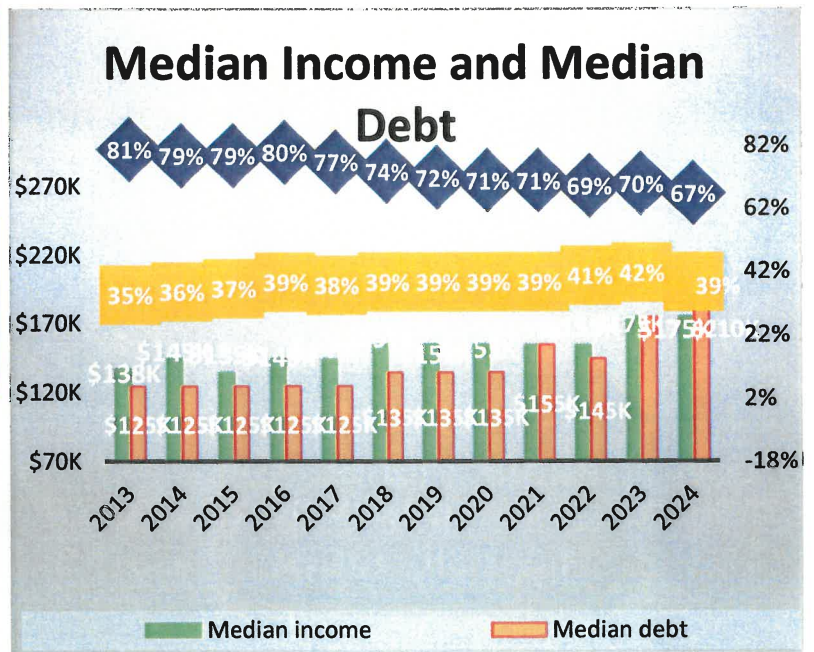
Decline in percent with debt

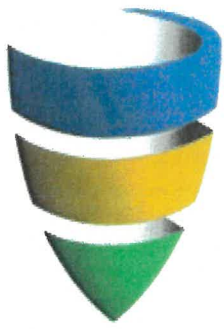


Both median income and debt are increasing



Median educ. debt is now higher than median income





Virginia Department of Health Professions

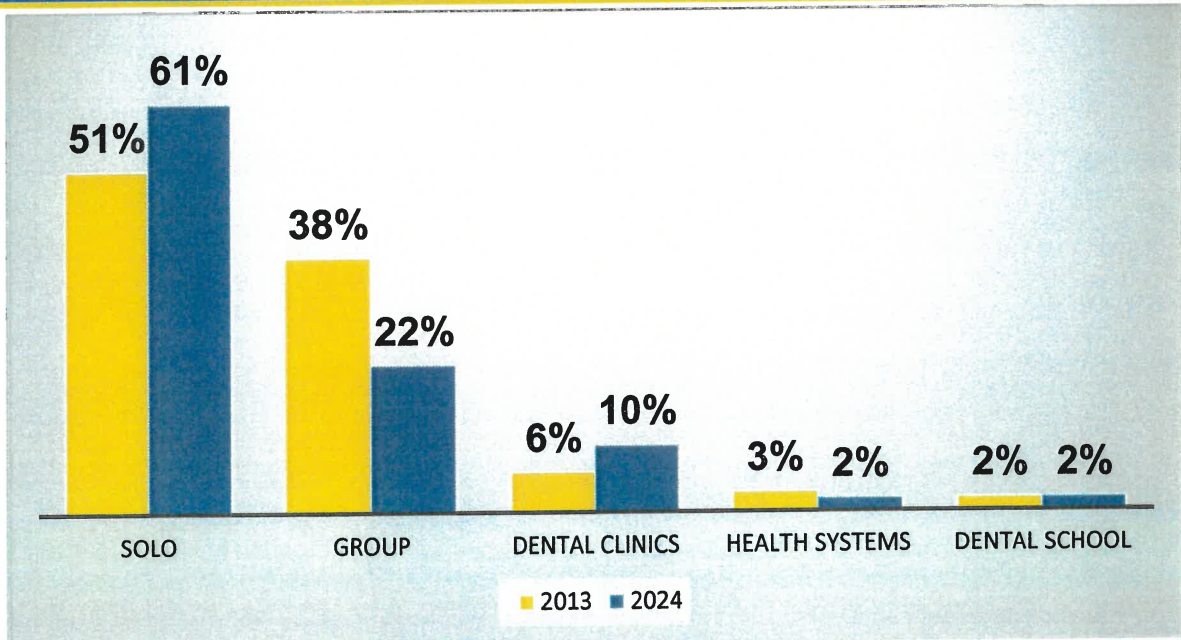


Top 5 Establishment Types



Increase in % working in solo private practice and dental clinics; decrease in % working in group private practice

SY(C



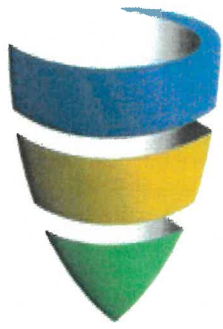
Used by permission of HWDC

Slide 9

SY(0

I'd like us to add dental clinic to this. We only have 2014 as comparison but it's worth including

Shobo, Yetty (DHP), 2025-03-18T21:22:08.701

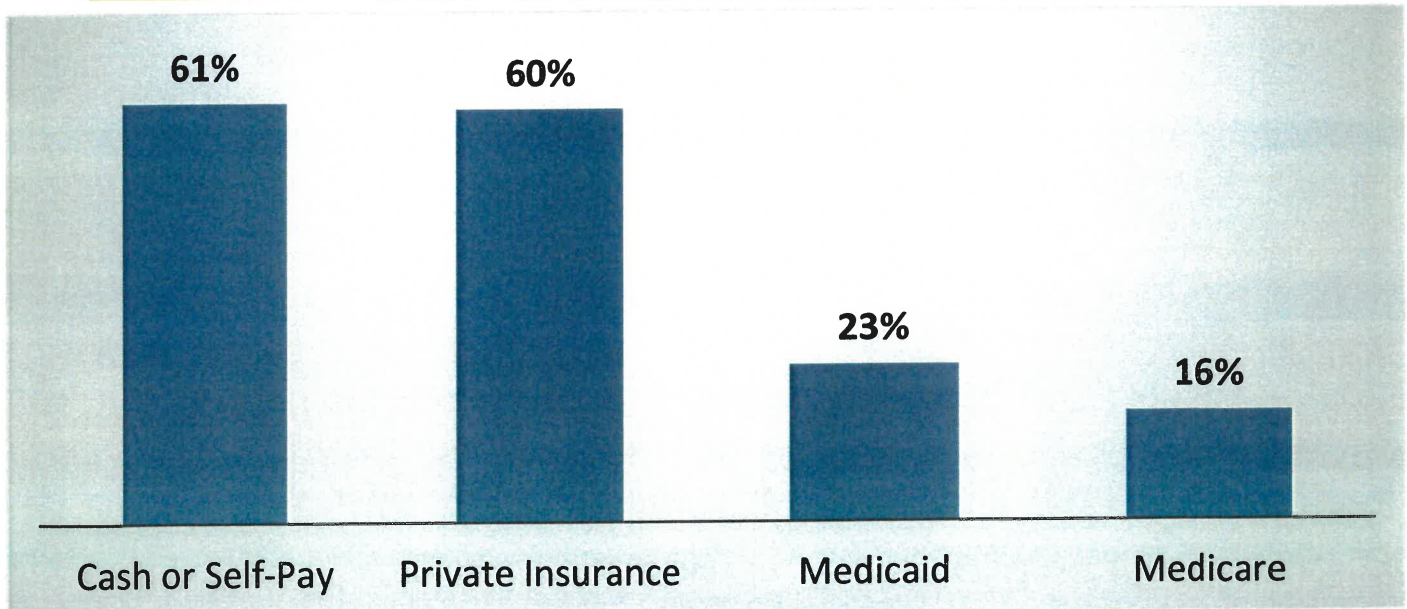


Virginia Department of Health Professions



Accepted Payment Types

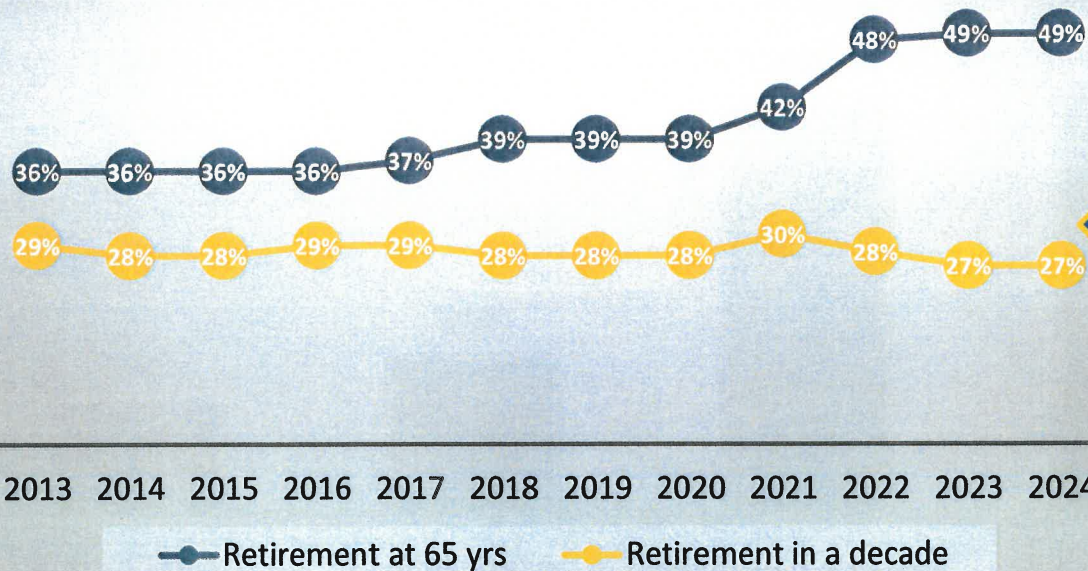
Majority accept cash and self pay,, followed by private insurance, Medicaid, and Medicare



Used by permission of HWDC

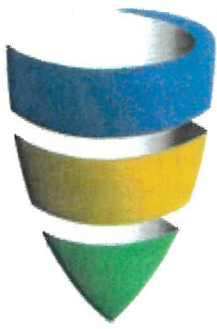


Trends in Retirement Intentions - Dentists



Increases in those expecting to retire by 65

Those expecting to retire within 10 yrs. have declined



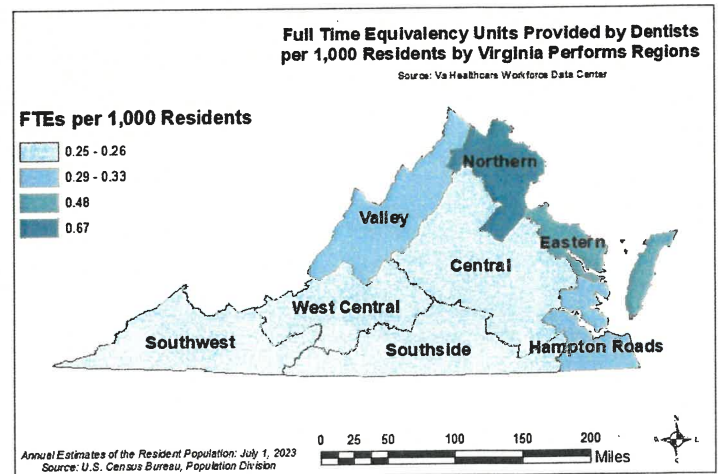
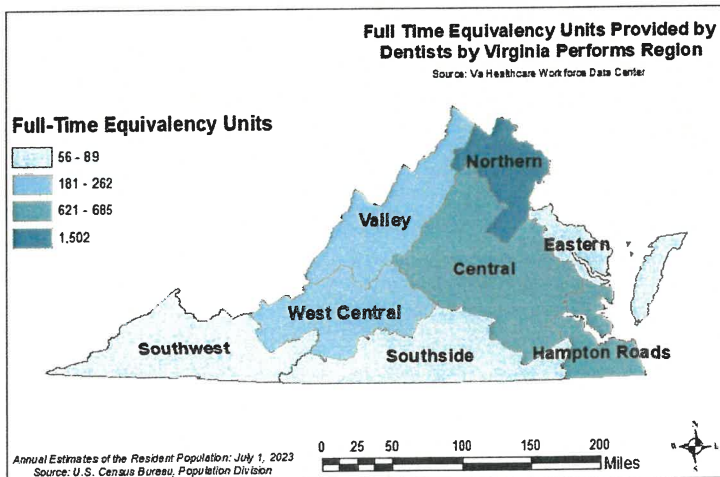
Virginia Department of Health Professions



Geographical Distribution



Central VA high in total FTEs, but low in FTEs per capita; Southwest and Southside VA low in both



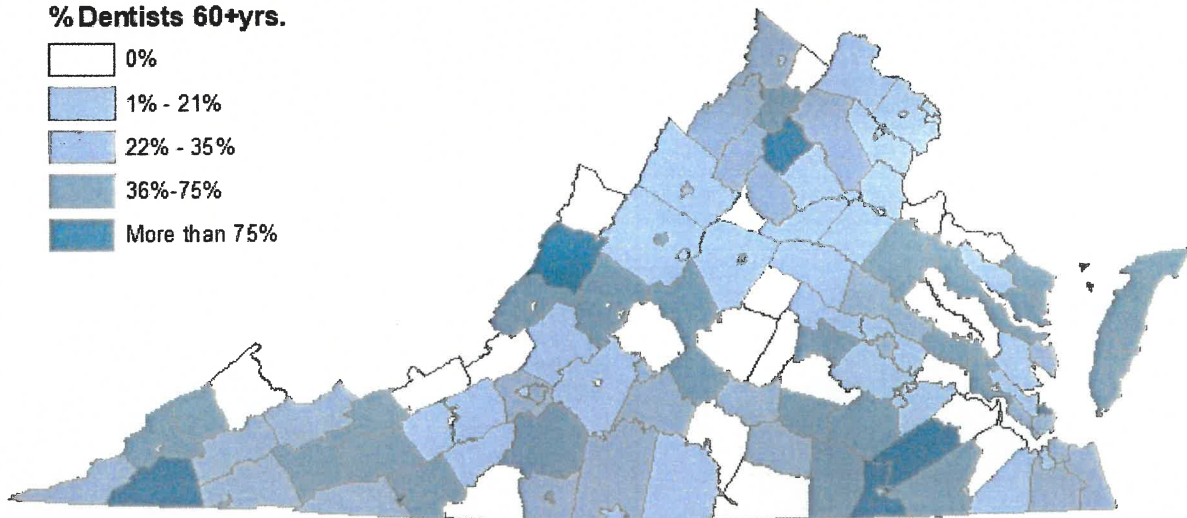
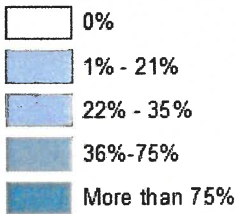
Used by permission of HWDC



Percent of Dentists Who Are Age 60 and Above

Source: Va Healthcare Workforce Data Center

% Dentists 60+yrs.



Annual Estimates of the Resident Population: July 1, 2023
Source: U.S. Census Bureau, Population Division








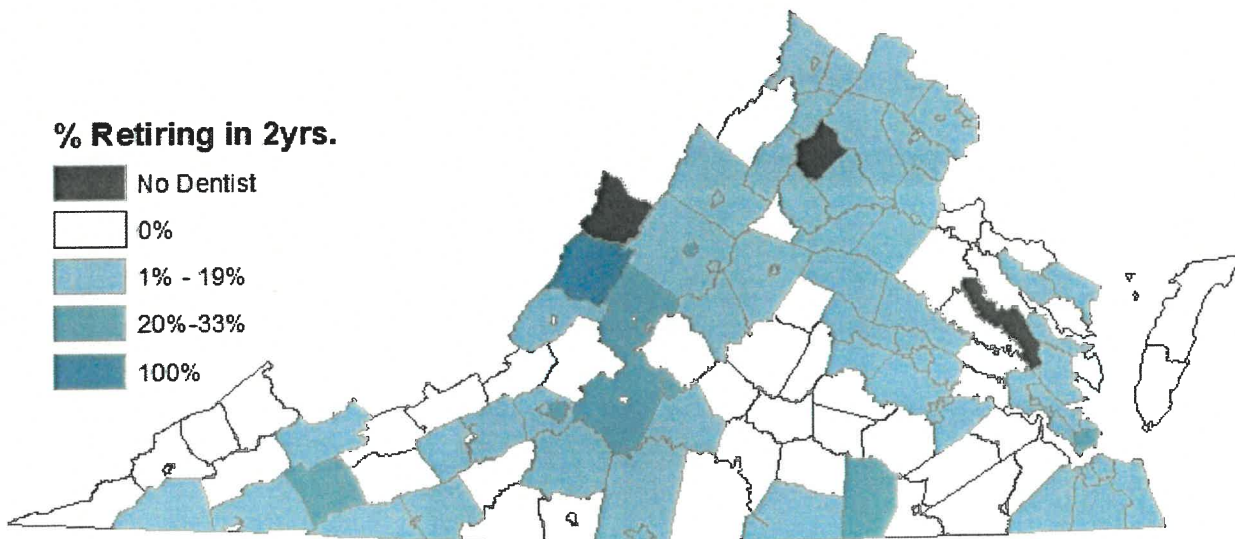


Percent of Dentists Retiring Within Two Years

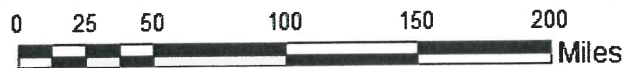
Source: Va Healthcare Workforce Data Center

% Retiring in 2yrs.

-  No Dentist
-  0%
-  1% - 19%
-  20% - 33%
-  100%



Annual Estimates of the Resident Population: July 1, 2023
Source: U.S. Census Bureau, Population Division





Virginia Department of Health Professions



Conclusion



Increase in licensees, VA's workforce, and FTEs



Younger age distribution and high diversity index



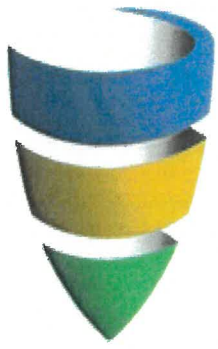
Median education debt higher than median income



Majority accept cash or insurance; increase in % working in solo practice and dental clinics



Some hotspot counties with no dentist FTEs or older dentists retiring soon.



Virginia Department of Health Professions



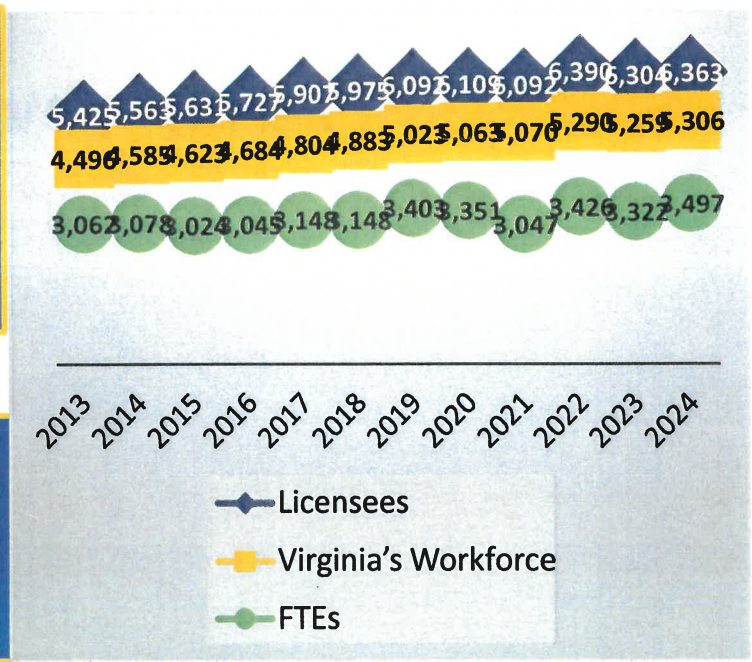
Dental Hygienists: 2024 Key Survey Findings

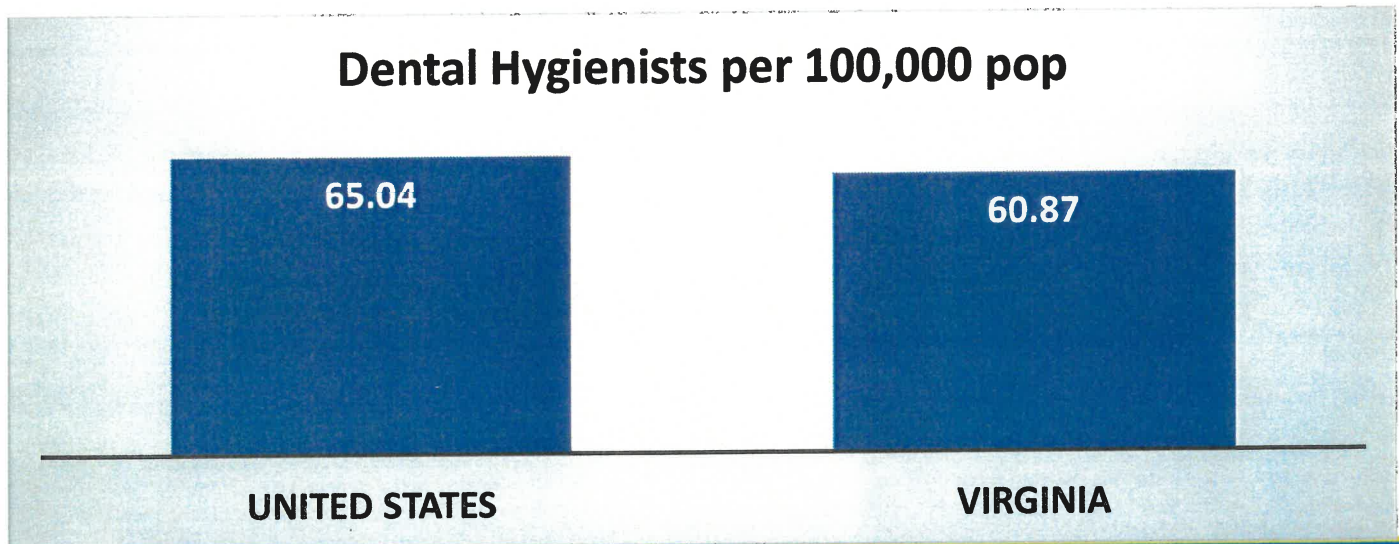


Trends in Dental Hygienist Licensees and Workforce

Since 2013, 17%, 18%, and 14% increase in licensees, workforce, and FTEs

Licensees: 6,363
Workforce: 5,306
FTEs: 3,497

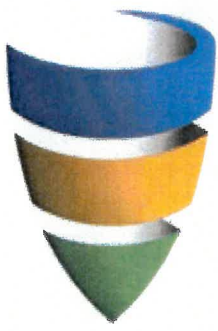




VA dental hygienist workforce is lower than the national workforce



5,306 dental hygienists (2.8% of 187,000 nationally) and about 46 dental assistants II worked in VA in 2024



Virginia Department of Health Professions



Trends in Demographics



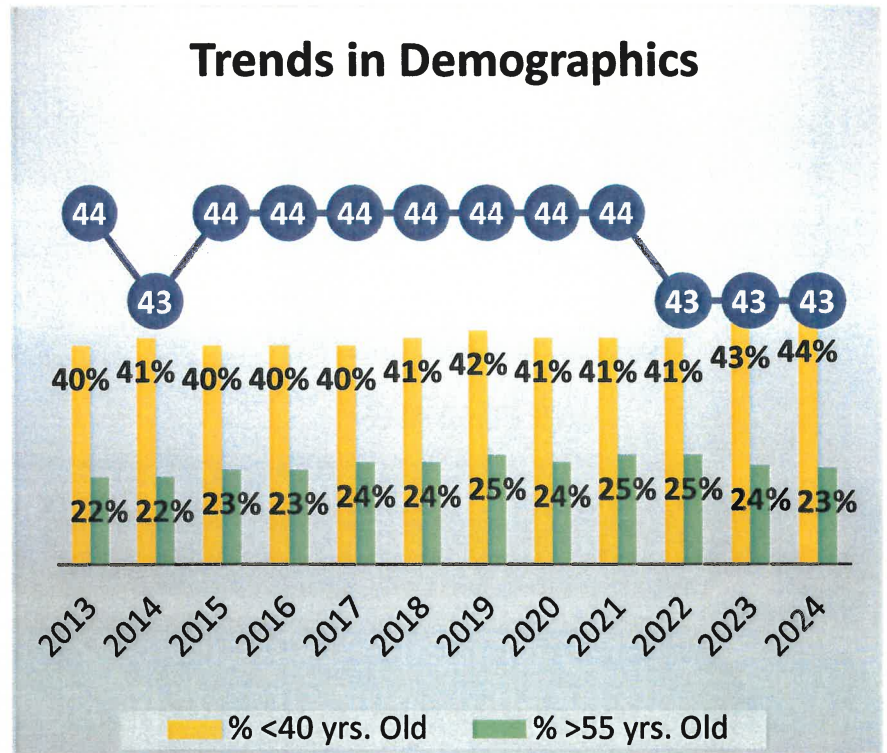
98% female since 2015



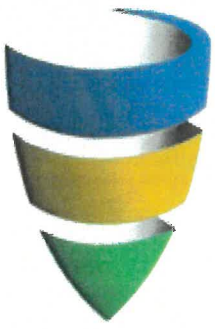
Median age stable at 43



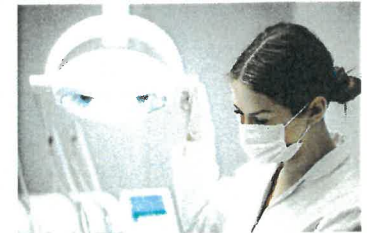
Some increase in percent under 40



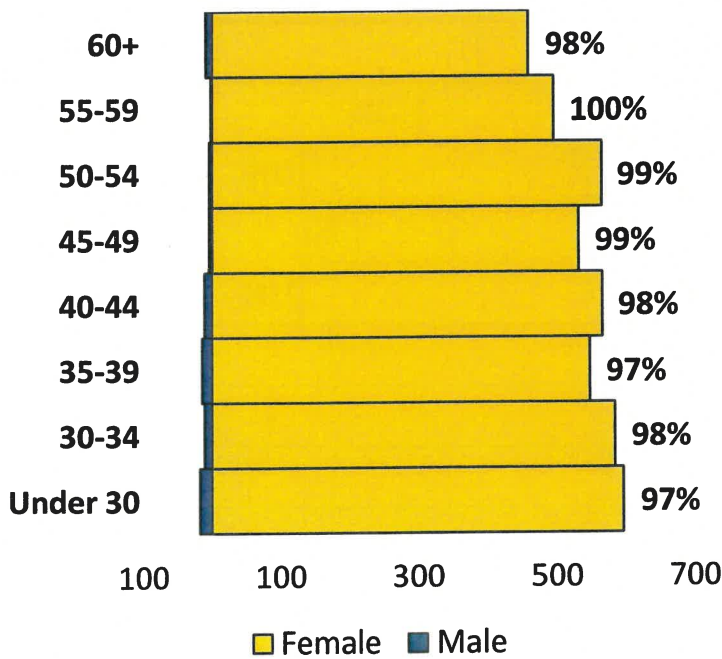
Used by permission of HWDC



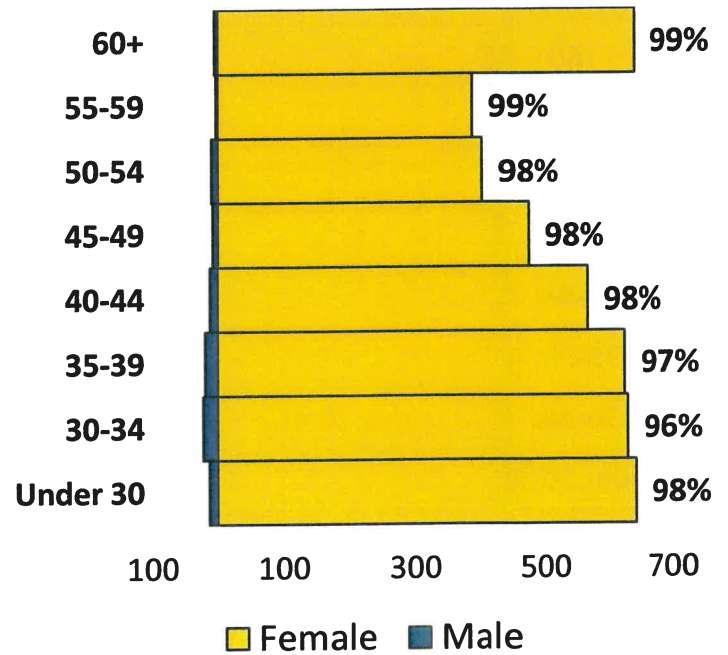
Virginia Department of Health Professions



2013 Dental Hygienist Population Pyramid



2024 Dental Hygienist Population Pyramid



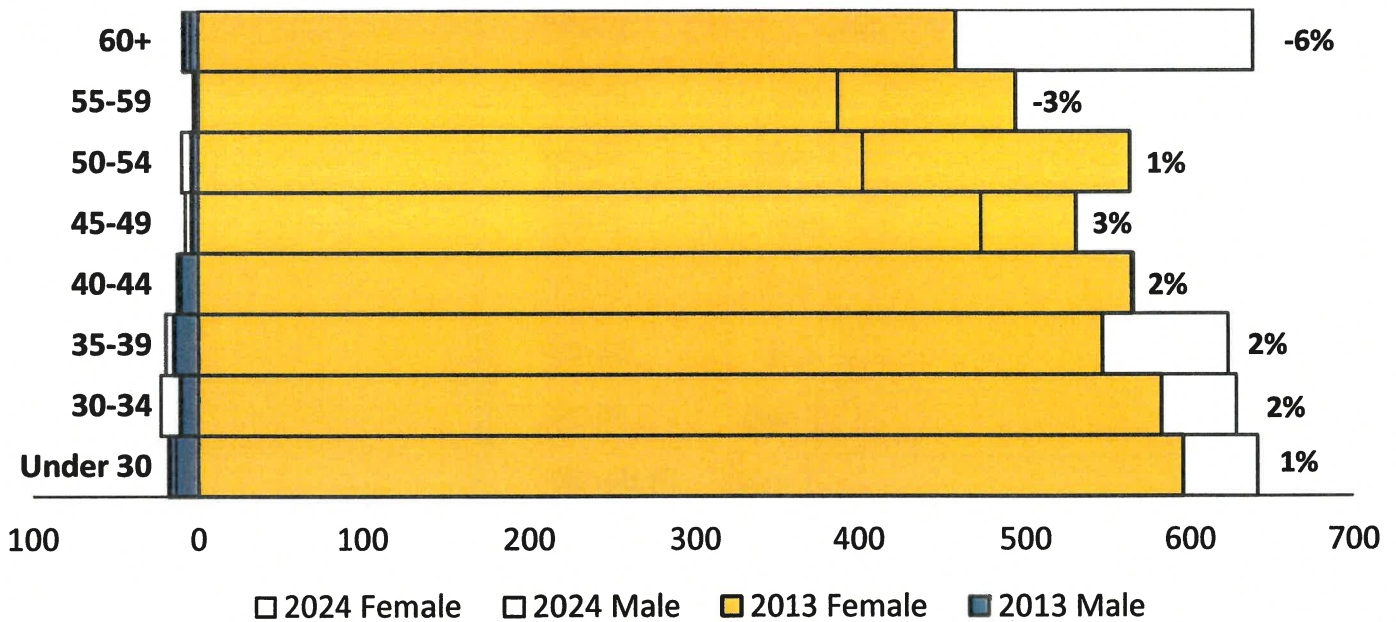
Used by permission of HWDC



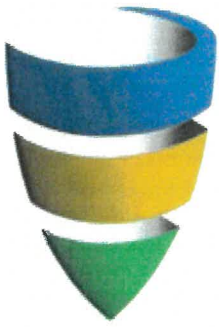
Virginia Department of Health Professions



2013 versus 2024 Dental Hygienist Population Pyramid



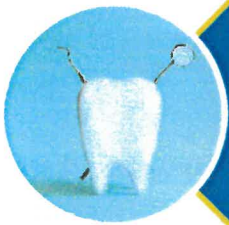
Used by permission of HWDC



Virginia Department of Health Professions



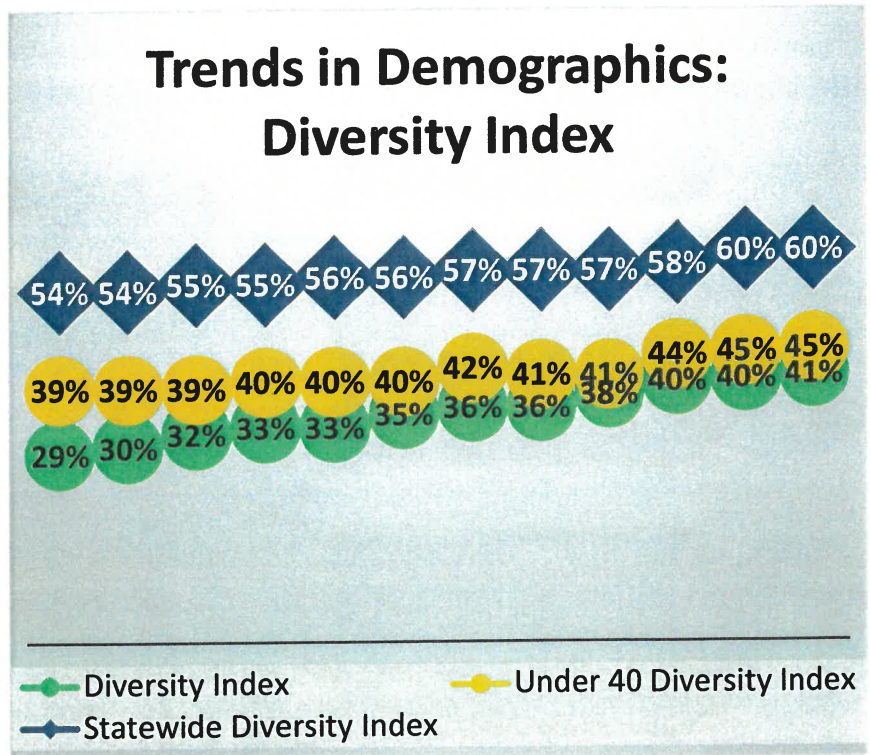
Trends in Demographics



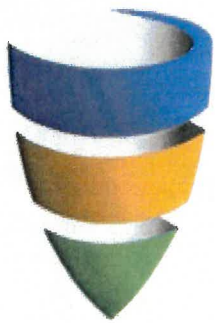
Diversity index increasing over time



index higher than workforce diversity



Used by permission of HWDC



Virginia Department of Health Professions



Trends in Educational Attainment



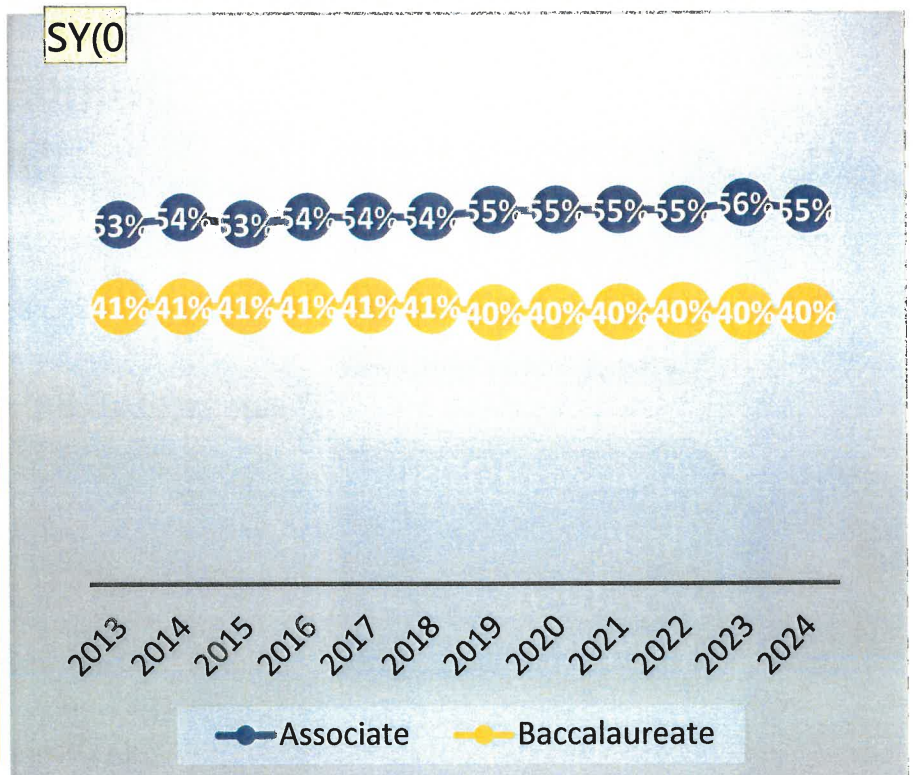
Over half hold an Associate's degree



About 40% hold a Bachelor's



Between 2%-3% have a Master's degree



Used by permission of HWDC

Slide 23

SY(0

Has there been increase in percent with bachelor's degree? If so, worth mentioning during presentation.
Shobo, Yetty (DHP), 2025-03-19T11:23:11.398



Trends in Income and Debt: Dental Hygienists



Median income increased for the first time in 5 years

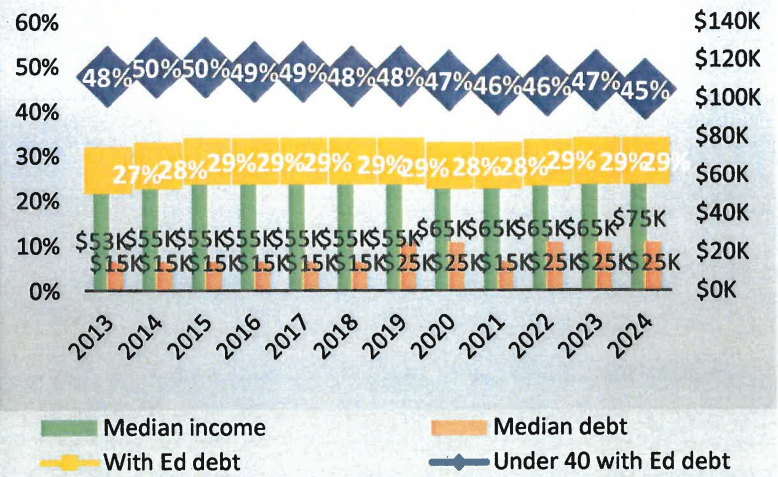


29% of workforce has education debt; median debt between \$15k-\$25k



45% of dental hygienists under 40 have education debt

Median Income and Median Debt

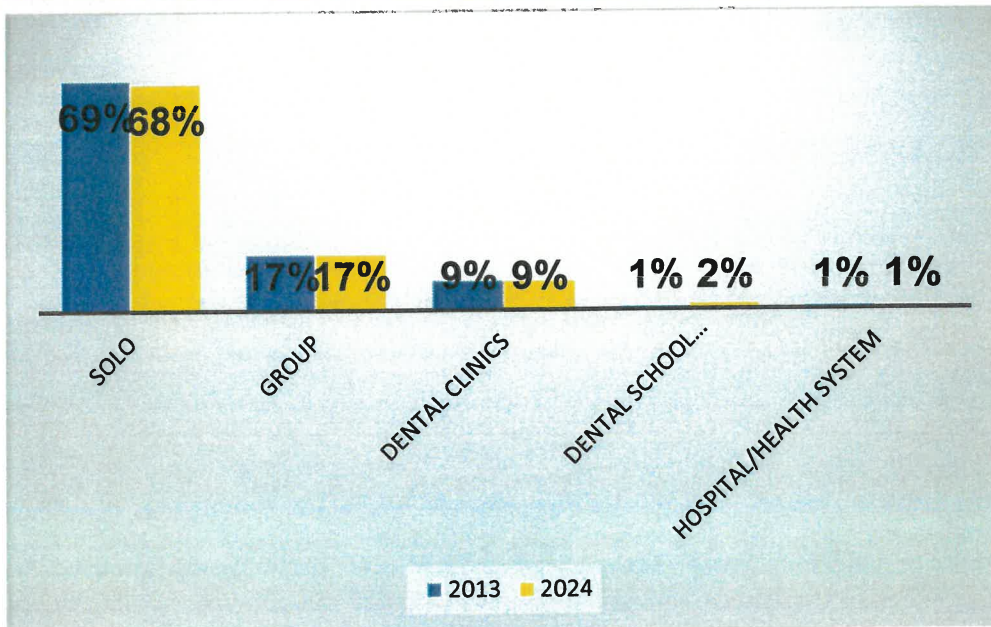




Top 5 Establishment Types



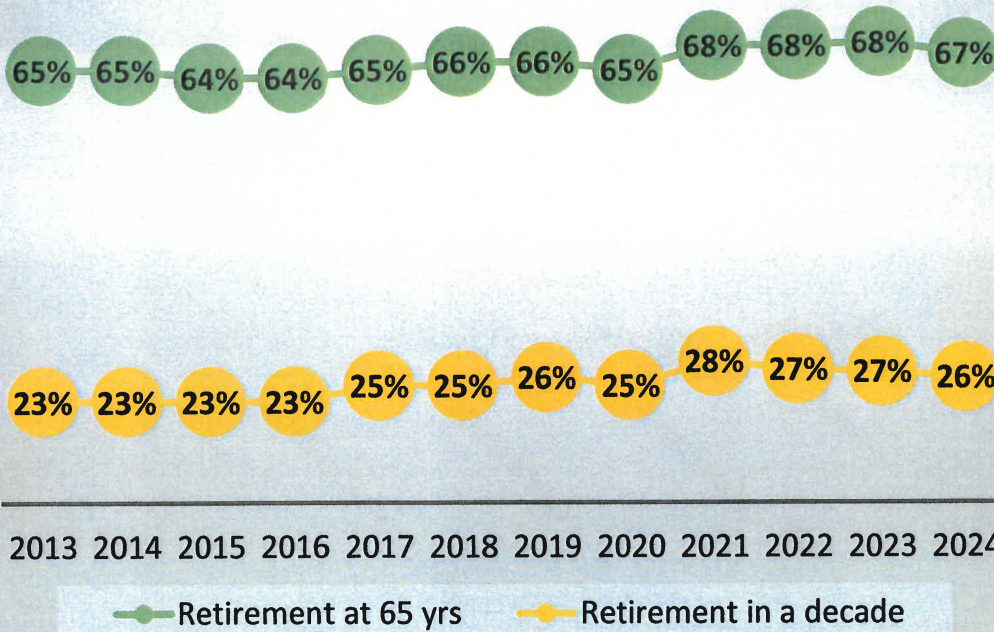
Slight decline in those working in solo practice and increase in those working in dental schools



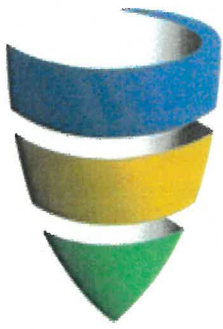
Used by permission of
HWDC



Trends in Retirement Intentions



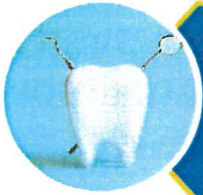
Over time, slight decline in retirement expectations



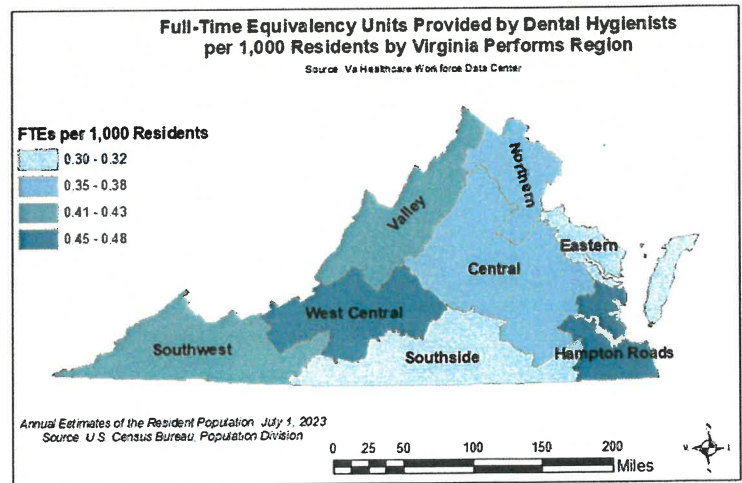
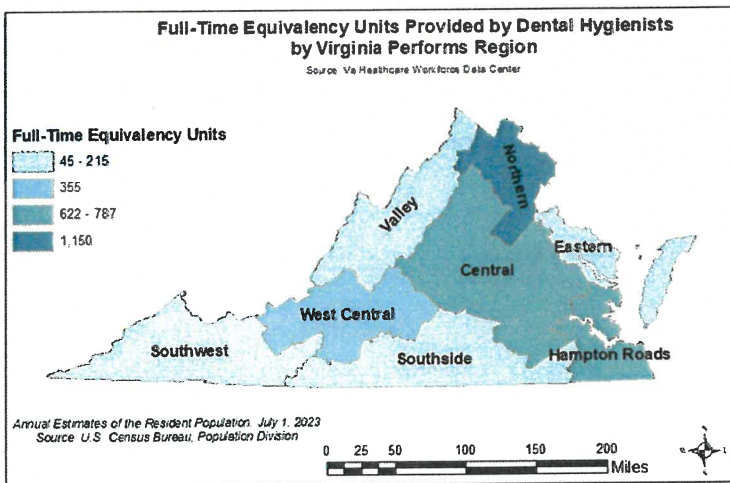
Virginia Department of Health Professions



Geographical Distribution



Northern and Central VA have high total FTEs, but low FTEs per capita; Southside and Eastern VA low in both. Hampton Roads has high total and per capita FTEs.








Used by permission of HWDC

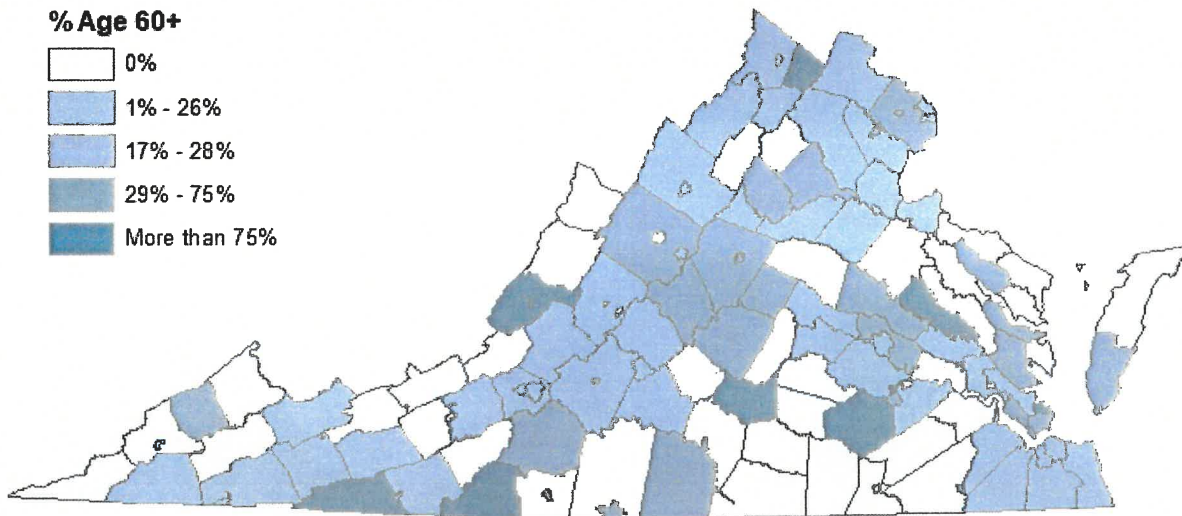


Percent of Dental Hygienists Who Are Age 60 and Above

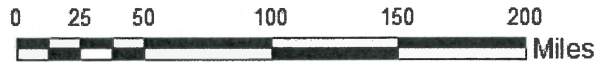
Source: Va Healthcare Workforce Data Center

% Age 60+

-  0%
-  1% - 26%
-  17% - 28%
-  29% - 75%
-  More than 75%



Annual Estimates of the Resident Population: July 1, 2023
Source: U.S. Census Bureau, Population Division








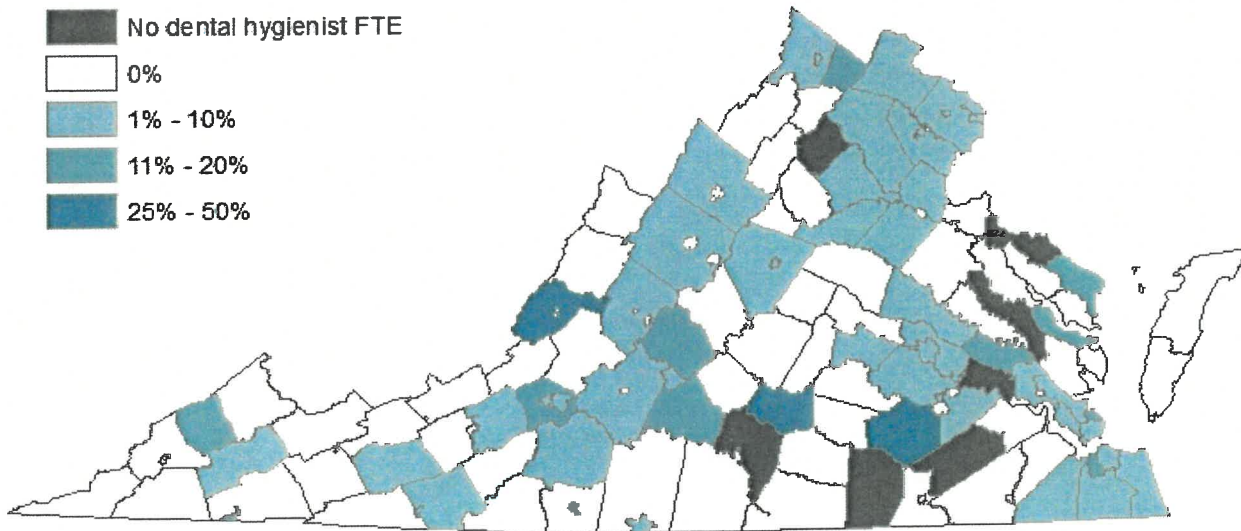


Percent of Dental Hygienists Retiring Within Two Years

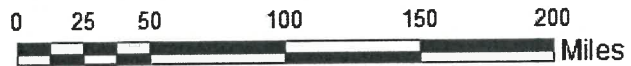
Source: Va Healthcare Workforce Data Center

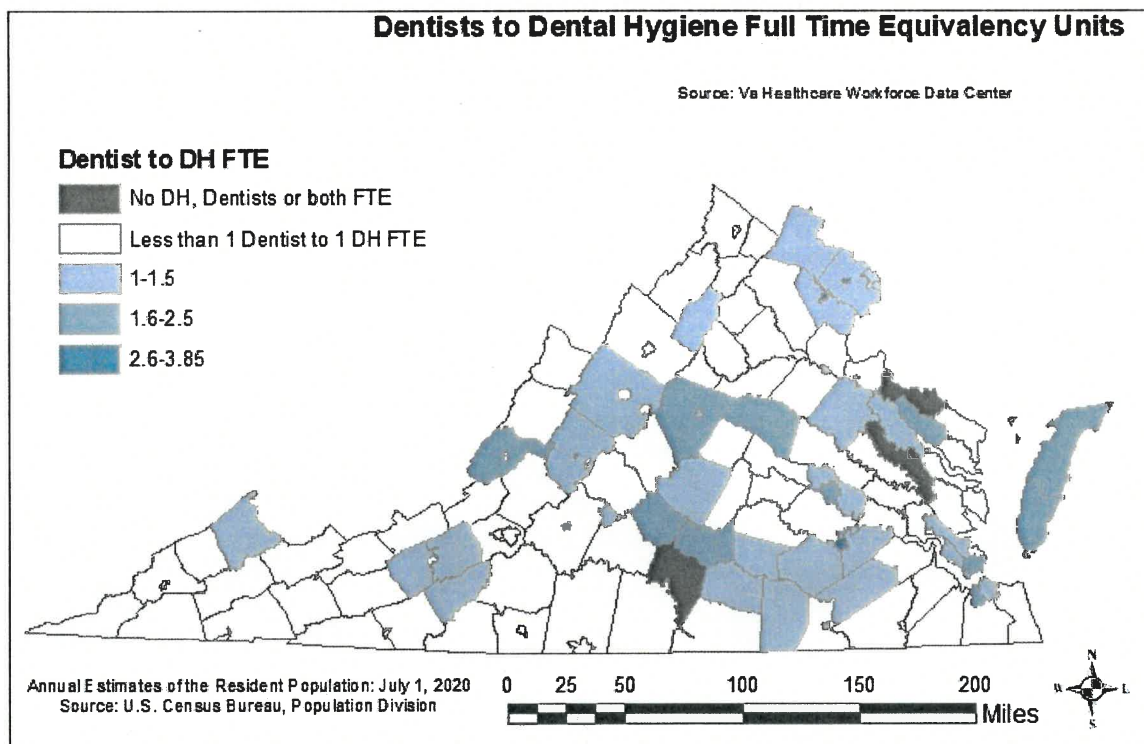
% Retiring in 2yrs.

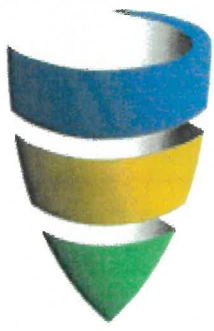
-  No dental hygienist FTE
-  0%
-  1% - 10%
-  11% - 20%
-  25% - 50%



Annual Estimates of the Resident Population: July 1, 2023
Source: U.S. Census Bureau, Population Division







Virginia Department of Health Professions



Conclusion



Slight increase in licensees, VA workforce, and FTEs



Majority female workforce, shrinkage of middle-aged DHs, increasing diversity index



Over half hold an Associate's degree



Median education debt lower than median income



Some counties have no DHs or will be losing up to 1/2 of their DHs soon



Virginia Department of
Health Professions



Thank you!



Credentialing

- Topic Questions for Credentialing
- Licensure Requirements by State
- Board of Medicine change in regulations
- Dentist- Current Laws and Regulations
- Dentist-Map of Active Practice Requirements
- DH-Current Laws and Regulations
- DH- Map of Active Practice Requirements



Virginia Department of
Health Professions
Board of Dentistry

Topic Questions for Licensing by Credentials

Dentist

1. The BOM was able to make changes to their active practice requirements because they are written in regulation and not in law.
 - a. Do you think the Board of Dentistry should recommend that the law is changed to lower the active practice requirements?
 - b. If so, are there any concerns that there are 27 other states that have the same or equal to active practice requirements as Virginia and most of them are surrounding states? Why are there no concerns?
2. What is the importance of requiring active practice requirements?
 - a. Patient Safety, maintaining competence
3. If you think we should lower active practice requirements, what number of years should be required? Of the states that have less experience requirements, they are the following:
 - a. 5 states require no experience
 - b. 1 state requires 30 days of experience
 - c. 2 states require 2 years of experience
 - d. 8 states require 3 years of experience
 - e. 1 state requires 4 years of experience
4. Are there any other factors that need to be considered regarding changing Credentialing requirements for Virginia?
 - a. Jurisprudence Exam is not required in Virginia
 - b. Educational Requirements?
 - c. Background Checks
5. In order for an internationally trained dentist to practice as a dentist in Virginia, they must be a graduate of and a holder of a diploma or a certificate from a dental program accredited by the Commission on Dental Accreditation of the American Dental Association or the Commission on Dental Accreditation of Canada, which consists of either a pre-doctoral dental education program (DDS or DMD) or at least a 12-month post-doctoral advanced general dentistry program or a post-doctoral dental program of at least 24 months in any other specialty that includes a clinical component.



Virginia Department of
Health Professions
Board of Dentistry

Dental Hygiene

1. The Board can promulgate regulations for active practice requirements for credentialing dental hygienists because the requirement is in regulations and not in code. Do you think the Board needs to lessen the active practice requirements of dental hygienists seeking credentialing? 18 states have no requirement or less active practice requirements than Virginia.
 - a. 7 states require no experience
 - b. 1 state requires 50 hours in 5 years
 - c. 1 state requires 30 days of experience
 - d. 9 states require 1 year of experience
2. What is the importance of requiring active practice requirements for dental hygienists?
 - a. Patient Safety, maintaining competence
3. Are there any other factors that need to be considered regarding changing Credentialing requirements for Virginia?
 - a. Jurisprudence Exam is not required in Virginia
 - b. Educational Requirements?
 - c. Background Checks

	<u>Jurisdiction</u>	<u>Application Fee-Endorsement</u>	<u>Education Requirements</u>	<u>Endorsement (Credentialing, Reciprocity) Experience Requirements</u>	<u>Foreign Educated Applicants</u>	<u>Background Check</u>	<u>Notes</u>
Alabama	X	\$2,500	(1) Pre-Dental. A minimum of three (3) years academic study of ninety (90) semester hours or its equivalent. This will include a minimum of: Biology (8 hours), Chemistry(16 hours)Physics(8 hours)Mathematics(6 hours) Non-Science (30 hours 12 of which must be English or its equivalent) (2) Must be a graduate of a school or college of dentistry approved by the Board.	The dentist shall have been engaged in the active practice of clinical dentistry or in full-time practice five years or 5,000 hours immediately preceding his or her application	X		
Alaska	X	\$1,450	Official transcripts sent directly to the department from the applicant's dental school verifying a dental degree and that, at the time of graduation, the school was accredited by the Commission on Dental Accreditation of the American Dental Association.	The dentist has practiced dentistry for a minimum of 5000 hours during the five years immediately before applying for licensure by credential. For purposes of this subsection, dental practice includes experience as a dental educator at a dental program accredited by the American Dental Association Commission on Dental Accreditation or employment as a dentist in a public health setting			
Arizona	X	\$410	Official transcripts from any school	The dentist has practiced dentistry for a minimum of 5000 hours during the five years immediately before applying for licensure by credential. For purposes of this subsection, dental practice includes experience as a dental educator at a dental program accredited by the American Dental Association Commission on Dental Accreditation or employment as a dentist in a public health setting			
Arkansas	X	\$1,000	Be a graduate of a school for the education and training of dentists approved by the Board and accredited by the American Dental Association's Commission on Dental Accreditation.	dentist who has been licensed and practicing continuously for the past five (5) years or more		X	
California	X	\$525	Be a graduate of a school for the education and training of dentists approved by the Board and accredited by the American Dental Association's Commission on Dental Accreditation.	Proof that the applicant has either been in active clinical practice or has been a full-time faculty member in an accredited dental education program and in active clinical practice for a total of at least 5,000 hours in five of the seven consecutive years immediately preceding the date of his or her application.	X	X	List of approved foreign schools
Colorado		unknown	Evidence of graduation with a DDS or DMD degree from an accredited dental school or college which at the time of the applicant's graduation was accredited by the American Dental Association Commission on Dental Education. An official school transcript of credits with the date of graduation and degree obtained shall be deemed sufficient evidence.	o Active practice of Dentistry in the US or Canada for at least 300 hours per year for at least 5 of the last 7 years o Teach Dentistry, including providing care to patients for at least 300 hours annually in an accredited program for at least 5 of the last 7 years o Service in the military as a Dentist for 1 of the last 5 years ■ Provide a recommendation and verification of clinical experience from a senior officer.			
Connecticut		\$569.75	A diploma or other certificate of graduation conferring a dental degree from a dental college or from a department of dentistry of a medical college accredited by the American Dental Association's Commission on Dental Accreditation or its successor organization	Has worked continuously as a licensed dentist in an academic or clinical setting in another state or territory for a period of not less than one year immediately preceding the application for licensure without examination.	X		
Delaware	X	N/A	all applicants to have a degree in dentistry (DDS, DMD) from a dental college or university accredited by the Commission on Dental Accreditation of the American Dental Association (ADA). Currently, the ADA has not accredited any schools outside the United States and Canada.	N/A		X	

	<u>Jurisprudence</u>	<u>Application Fee</u>	<u>Education Requirements</u>	<u>Endorsement (Credentialing, Reciprocity) Experience Requirements</u>	<u>Foreign Educated Applicants</u>	<u>Background Checks</u>	<u>Notes</u>
DC	X	\$430	(a) Successfully completed an educational program in the practice of dentistry at an institution recognized by the Commission on Dental Accreditation of the American Dental Association (ADA) at the time the applicant graduated in accordance with § 504(d) of the Act, D.C. Official Code § 3-1205.04(d) (1985); and (b) Received a U.S., including U.S. territories, or Canadian Issued Doctor of Dental Surgery (DDS) or Doctor of Dental Medicine (DMD) degree.	Submit evidence satisfactory to the Board establishing that the applicant has been actively engaged in the practice of dentistry, in another U.S. state, in good standing, for the five (5) years immediately preceding the application, and has at least eight hundred and fifty (850) hours of active dental practice. The practice of dentistry in the armed forces, state and federal programs, and intern and residency programs may be counted toward the required hours of active practice		X	
Florida	X	\$405	Completes a program of study, as defined by the board by rule, at an accredited American dental school and demonstrates receipt of a D.D.S. or D.M.D. from said school; or Submits proof of having successfully completed at least 2 consecutive academic years at a full-time supplemental general dentistry program accredited by the American Dental Association Commission on Dental Accreditation. This program must provide didactic and clinical education at the level of a D.D.S. or D.M.D. program accredited by the American Dental Association Commission on Dental Accreditation	Full-time practice of dentistry within the geographic boundaries of this state within 1 year is defined as a minimum of 1,200 hours in the initial year of licensure, which must include any combination of the following: -Active clinical practice of dentistry providing direct patient care within the geographic boundaries of this state. -Full-time practice as a faculty member employed by a dental or dental hygiene school approved by the board or accredited by the American Dental Association Commission on Dental Accreditation and located within the geographic boundaries of this state. -Full-time practice as a student at a postgraduate dental education program approved by the board or accredited by the American Dental Association Commission on Dental Accreditation and located within the geographic boundaries of this state. Failure to meet this requirement will cause the license to expire. Please review s. 466.006(6), F.S. for additional information concerning the specific requirements.			
Georgia	X	\$3,025	An official transcript which documents graduation with a D.D.S. or D.M.D. degree from a dental school which is accredited by the American Dental Association Commission on Dental Education.	An affidavit from the applicant stating employment for the five years immediately preceding application: (A) the dates and locations where the applicant has practiced dentistry; and (B) that the applicant has been in full time clinical practice of a minimum of 1000 hours per year in the hands on treatment of patients. Training programs do not qualify as full time clinical practice.			
Hawaii		\$448	Be a graduate of a dental college accredited by the American Dental Association Commission on Dental Accreditation	No experience requirements		May be required	
Idaho	X	\$400	Applicants for licensure to practice dentistry must furnish proof of graduation from a school of dentistry accredited by CODA at the time of applicant's graduation	The applicant has been in clinical practice at least five (5) years immediately preceding the date of application for a minimum of three thousand five hundred (3,500) hours			
Illinois		\$250	Present satisfactory evidence of completion of dental education by graduation from a dental college or school in the United States or Canada approved by the Department. The Department shall not approve any dental college or school which does not require at least (A) 60 semester hours of collegiate credit or the equivalent in acceptable subjects from a college or university before admission, and (B) completion of at least 4 academic years of instruction or the equivalent in an approved dental college or school that is accredited by the Commission on Dental Accreditation of the American Dental Association	at least 3 of the 5 years immediately preceding the filing of his or her application to practice in this State		X	
Indiana	X	\$250	have graduated from a dental school accredited by the Commission on Accreditation of the American Dental Association	has practiced dentistry for at least two (2) of the three (3) years preceding the date of application		X	
Iowa	X	\$550	A dentist who is a graduate of an ADA-accredited dental school	has at least three years of current, active practice in another state may be eligible for a permanent dental license issued on the basis of credentials		X	

	<u>Jurisdiction</u>	<u>Application Fee-Endorsement</u>	<u>Education Requirements</u>	<u>Endorsement (Credentialing, Reciprocity) Experience Requirements</u>	<u>Foreign Educated Applicants</u>	<u>Background Checks</u>	<u>Notes</u>
Kansas	X	\$300	Any graduate of an accredited dental school, dental college or dental department of a college or university, who: (1) Has a D.D.S. or D.M.D. degree and is otherwise qualified	Each applicant for licensure as a dentist under this section shall have held a license to practice dentistry in one or more other states of the United States for the five-year period immediately preceding the date of application and shall have engaged in the active practice of dentistry for at least five years prior to the date of application.	X		
Kentucky	X	\$325	Provide proof that the applicant is a graduate of a Commission on Dental Accreditation (CODA) accredited dental school or college or dental department of a university	Provide proof that, for five (5) of the six (6) years immediately preceding the filing of the application, the applicant has been engaged in the active practice of dentistry when he or she was legally authorized to practice dentistry in a state or territory of the United States or the District of Columbia if the qualifications for the authorization were equal to or higher than those of the Commonwealth of Kentucky.		X	
Louisiana	X	\$2,100	Have graduated from a dental school that was accredited at the time of the applicant's graduation by the Commission on Dental Accreditation of the American Dental Association	Demonstrate appropriate practice history by one of the following: a. Have practiced dentistry (or worked full time in dental education as a teacher) for at least 1000 hours per year for each of the three years immediately preceding the Louisiana LBC application; OR b. Have completed a residency in a Board recognized specialty or two year GPR and apply for licensure within 180 days of the completion of the residency.			
Maine	X	\$871	Verification of Doctoral Degree (either official transcript submitted by applicant or form submitted directly by the academic institution). Additional requirements if not CODA Accredited.	If actively licensed and practicing during three consecutive years immediately preceding the application, then you will be prompted to include a link to the licensing jurisdiction(s) regulations as part of the online licensure application	X	X	
Maryland	X	\$450	Hold a Degree of Doctor of Dental Surgery, Doctor of Dental Medicine, or its equivalent, from a college or university that is authorized by any state of the United States or any province of Canada to grant a degree and is recognized by the Board as requiring adequate preprofessional collegiate training and as maintaining an acceptable course of dental instruction. CODA Accredited	a notarized affidavit indicating that you have been actively practicing dentistry for at least 5 years, and that during the 5-year period preceding your application you have been actively engaged in practicing dentistry for at least 850 hours on average per year for a total of at least 4,250 hours	X		Foreign educated applicants have a restricted license
Massachusetts	X	\$660	An original transcript with the college seal indicating the degree granted and the date of graduation from a CODA-accredited dental school	Proof satisfactory to the Board of a minimum of five years of practice in dentistry or dental education immediately preceding the application for licensure by credentials. An applicant may include private practice; the practice of dentistry in the armed forces; federal, state, and municipal programs; and intern and residency programs as part of this five year dental practice requirement			
Michigan		\$316.20	Graduation from an ADA accredited dental program where a Doctor of Dental Surgery (DDS) or a Doctor of Dental Medicine (DMD) degree was awarded.	Has held a license as a dentist in good standing in another state for 30 days before filing an application in this state.		X	
Minnesota	X	\$926.25	Graduate from a dental school that is accredited by the Commission on Dental Accreditation	Have been in active practice for 2000 hours of the previous 36 months in another state, Canadian Province, or U.S. government service.	X- Test of English as a Foreign Language (TOEFL) Scores	X	Uses Foreign Credentials Service of America for foreign applicants, extra \$200 fee
Mississippi	X	2,500.00	Graduate from a dental school that is accredited by the Commission on Dental Accreditation	A dentist must have practiced a minimum of five (5) years from the date the application is received to be considered for licensure by credentials. A candidate must practice a minimum of ninety (90) days per year from the date the application for licensure by credentials is received to be considered as actively practicing for the past five (5) years.			
Missouri	X	\$150	Be a graduate of and hold a Doctor of Dental Surgery (DDS) degree or a Doctor of Dental Medicine (DMD) degree from an accredited dental school as defined in section 332.011, RSMo, and meet the other requirements of sections 332.131 and 332.151, RSMo	1 year of licensure that is equal	X		

	<u>Jurisprudence</u>	<u>Application Fee-Endorsement</u>	<u>Education Requirements</u>	<u>Endorsement (Credentialing, Reciprocity) Experience Requirements</u>	<u>Foreign Educated Applicants</u>	<u>Background Checks</u>	<u>Notes</u>
Montana	X	\$685	Applicant shall have graduated from an accredited Commission on Dental Accreditation Dental School (CODA)	provides evidence that the applicant has been engaged in the practice of clinical, direct patient care dentistry at least six months prior to the date of application and can demonstrate actively practicing within the last five years immediately preceding application, for a total accumulation of 3000 hours of experience			
Nebraska	X	\$165	present proof of graduation with a Doctor of Dental Surgery degree or a Doctor of Dental Medicine degree from an accredited school or college of dentistry	been actively engaged in the practice of dentistry or X been in a residency or graduate training program for at least three years (one of those years must be within the last three years).		X	
Nevada	X	\$1,200	Graduate from a dental school that is accredited by the Commission on Dental Accreditation	Must provide proof that they have actively practiced X dentistry for 5 years immediately preceding the date of submission of the application.		X	
New Hampshire	X	\$198	Applicants are required to be graduates of a school that awards the degree of Doctor of Dental Medicine (DMD) or Doctor of Dental Surgery (DDS) and is recognized by the American Dental Association Commission on Dental Accreditation, and are eligible for licensure either by examination or endorsement certificate.	Any person holding a current, unsuspended, unrestricted license to practice dentistry in one or more states, and who has taken and passed the American Board of Dental Examiners (ADEX) examination or other similar U.S. regional or state board clinical examination for dentists, including a periodontal/scaling exam, and who throughout the 3 years immediately prior to submitting the application, has practiced clinical dentistry in one or more states, shall be considered for licensure by endorsement.		X	
New Jersey	X	\$125	You must have graduated from a dental program recognized by the Commission on Dental Accreditation (CODA) of the American Dental Association.	Evidence demonstrating that the applicant has actively practiced dentistry, which may include practice in a dental residency, in a single state or jurisdiction for at least five years prior to the date of application		X	
New Mexico	X	\$850	Graduated and received a diploma from an CODA-accredited dental school	Hold a valid license in good standing by clinical exam in another state for five years or more		X	
New York		\$377	not less than 60 semester hours of preprofessional education, including courses in general chemistry, organic chemistry, biology or zoology, and physics; and a program of professional education consisting of either: at least four academic years, or the equivalent thereof, in a program registered by the Department as licensure qualifying or accredited by an accrediting organization acceptable to the Department (see below for information about accredited dental programs); or at least four academic years of dental education satisfactory to the Department, culminating in a degree, diploma or certificate in dentistry recognized by the appropriate civil authorities of the country in which the school is located, as acceptable for entry into practice in the country in which the school is located.	Supporting Affidavit of Professional Practice for X Endorsement Applicants (Form 4A) to document two years of full-time practice			
North Carolina	X	\$2,000	graduated from a dental school accredited by the Commission on Dental Accreditation of the American Dental Association	an affidavit from the applicant stating for the five years immediately preceding the application: (A) the dates that and locations where the applicant has practiced dentistry; (B) that the applicant has provided at least 5,000 hours of clinical care directly to patients, not including post graduate training, residency programs or an internship; and (C) that the applicant has continuously held an active, unrestricted dental license issued by another U.S. state or U.S. territory;		X	
North Dakota	X	\$1,320	Has a DDS or DMD diploma from a dental program accredited by the Commission on Dental Accreditation of the American Dental Association	licensed and has been actively practicing dentistry for five years immediately preceding application in another jurisdiction where the requirements are at least substantially equivalent to those of this state may apply to the North Dakota State Board of Dental Examiners for a License by Credential		X	Has to have an optometric evaluation

	<u>Jurisdiction</u>	<u>Application Fee-Endorsement</u>	<u>Education Requirements</u>	<u>Endorsement (Credentialing, Reciprocity) Experience Requirements</u>	<u>Foreign Educated Applicants</u>	<u>Background Checks</u>	<u>Notes</u>
Ohio	X	\$454	Be a graduate of an accredited dental college, or a graduate of an unaccredited dental college located outside the United States and meets the requirements set forth in rule 4715-18-01 of the Administrative Code	Actively practice for 1 year immediately preceding the date of the application.	X- Test of English as a Foreign Language (TOEFL) Scores	X	
Oklahoma	X	\$500	graduate from an accredited dental school	Have been practicing 5 years immediately prior to making application	X		
Oregon	X	\$790	(a) Having graduated from a school of dentistry accredited by the Commission on Dental Accreditation of the American Dental Association; or (b) Having graduated from a dental school located outside the United States or Canada, completion of a predoctoral dental education program of not less than two years at a dental school accredited by the Commission on Dental Accreditation of the American Dental Association, and proficiency in the English language	Having conducted licensed clinical practice in Oregon, other states or in the Armed Forces of the United States, the United States Public Health Service or the United States Department of Veterans Affairs for a minimum of 3,500 hours in the five years immediately preceding application. Licensed clinical practice could include hours devoted to teaching by dentists employed by a dental education program in a CODA accredited dental school, with verification from the dean or appropriate administration of the institution documenting the length and terms of employment, the applicant's duties and responsibilities, the actual hours involved in teaching clinical dentistry, and any adverse actions or restrictions	X	X	
Pennsylvania		\$235	Doctor of Dental Surgery - Candidates for licensure as dentists shall submit certification of graduation from a dental school accredited or provisionally accredited by the Commission on Accreditation of the American Dental Association.	Act 41 allows for portability of out-of-state professional licensees coming to work in Pennsylvania. Act 41 does this by granting all boards and commissions within the Commonwealth the authority to endorse licensees from other states, territories, or jurisdictions (with substantially equivalent licensing requirements) who are active, in good standing and without discipline against their license or criminal conviction.	X	X	
Rhode Island		\$965	Be a graduate of a school of dentistry accredited by the American Dental Association Commission on Dental Accreditation or its designated agency and approved by the Board;	Hold a current license in good standing to practice dentistry in another state for five (5) years immediately prior to submitting an application for licensure in RI. Said state shall have required successful completion of a clinical exam, not part of the applicant's training program, to be considered for RI licensure.			
South Carolina	X	\$2,000	Present to the Board satisfactory evidence of graduation from a dental college approved by the Commission on Accreditation of Dental and Dental Auxiliary Educational Programs of the American Dental Association.	been actively practicing dentistry for a minimum of five years immediately preceding the date of application. "Actively practicing" means working a minimum of twelve hundred hours a year in a private practice or public health or military clinical setting or the combination of twelve hundred hours a year of clinical instructing at a Commission on Dental Accreditation approved dental school and private practice			
South Dakota	X	\$725	Certified transcripts from an American Dental Association Commission on Dental Accreditation accredited United States dental school or a certified letter from the school verifying the applicant's graduation status.	The applicant is currently an active, competent practitioner, having completed a minimum of three thousand dental clinical hours within the five years immediately preceding the date of application		X	

	<u>Jurisprudence</u>	<u>Application Fee- Endorsement</u>	<u>Education Requirements</u>	<u>Endorsement (Credentialing, Reciprocity) Experience Requirements</u>	<u>Foreign Educated Applicants</u>	<u>Background Checks</u>	<u>Notes</u>
Tennessee	X	\$422.50	An applicant shall cause to be submitted directly, from a dental school, college or university duly accredited by the Commission on Dental Accreditation of the American Dental Association, to the Board Administrative Office a certificate of graduation containing the Institution's Official Seal	(A) Practiced dentistry in another state or states for at least five (5) years; (B) Taught in an American Dental Association accredited institution for at least five(5) years; (C) Any combination of subdivision (b)(6)(A) or subdivision (b)(6)(B) for at least five(5) years; (D) Practiced dentistry for at least two (2) years in another state or states and, in addition, presents satisfactory evidence of passing an examination administered by another state substantially equivalent to the examination required for initial licensure in Tennessee, the appropriateness of such examinations to be evaluated and determined by the board; (E) Taught for at least two (2) years in an American Dental Association accredited institution and, in addition, presents satisfactory evidence of passing an examination administered by a regional testing agency or a clinical board examination administered by another state substantially equivalent to the examination required for initial licensure in Tennessee, the appropriateness of such examination to be evaluated and determined by the board			X
Texas	X	\$2,945	Has graduated and received either the DDS or DMD degree from a dental school accredited by CODA	(8) has practiced dentistry or dental hygiene: (A) for at least the three years preceding the date of application for a license under this section; or (B) as a dental educator at a dental school or dental hygiene school accredited by the Commission on Dental Accreditation of the American Dental Association for at least the five years preceding the date of application for a license under this section	X		X
Utah		\$110	provide satisfactory documentation of having successfully completed a program of professional education preparing an individual as a dentist as evidenced by having received an earned doctor's degree in dentistry from a dental school accredited by the Commission on Dental Accreditation of the American Dental Association	document having been successfully engaged in clinical practice as a dentist for not less than 6,000 hours in the five years immediately preceding the date of application for licensure.			
Vermont	X	\$250	(2) be a graduate of: (A) a dental college accredited by the Commission on Dental Accreditation of the American Dental Association; or (B) a program of foreign dental training and a postgraduate program accredited by the Commission on Dental Accreditation of the American Dental Association that is acceptable to the Board	has been in full-time licensed practice of at least 1,200 hours per year for a minimum of five years preceding the application	X		
Virginia		\$500	An applicant for unrestricted dental licensure shall be a graduate of and a holder of a diploma or a certificate from a dental program accredited by the Commission on Dental Accreditation of the American Dental Association or the Commission on Dental Accreditation of Canada, which consists of either a pre-doctoral dental education program or at least a 12-month post-doctoral advanced general dentistry program or a post-doctoral dental program of at least 24 months in any other specialty that includes a clinical component.	Have been in continuous clinical practice in another jurisdiction of the United States or in federal civil or military service for five out of the six years immediately preceding application for licensure pursuant to this section. Active patient care in another jurisdiction of the United States (i) as a volunteer in a public health clinic, (ii) as an intern, or (iii) in a residency program may be accepted by the board to satisfy this requirement. One year of clinical practice shall consist of a minimum of 600 hours of practice in a calendar year as attested by the applicant.			

	<u>Jurisdiction</u>	<u>Application Fee-Endorsement</u>	<u>Education Requirements</u>	<u>Endorsement (Credentiaing, Reciprocity) Experience Requirements</u>	<u>Foreign Educated Applicants</u>	<u>Background Checks</u>	<u>Notes</u>
Washington	Y	\$500	Applicants must graduate from a Commission on Dental Accreditation (CODA)-accredited dental school with a doctor of dental surgery (DDS) or doctor of dental medicine degree (DMD). Official school transcript with degree posted, or, for recent graduates, a verified list of graduating students submitted directly from the dean, is required. Or Graduates from non-accredited dental schools must also meet the requirements outlined in WAC 246-817-160. Evidence of successful completion of at least two additional predoctoral or postdoctoral academic years of dental education. Official school transcript or letter from school verifying education is required. Additional predoctoral or postdoctoral dental education completed before July 1, 2018, must be obtained at a dental school in the United States or Canada, approved, conditionally or provisionally, by the Commission on Dental Accreditation.	(5) Proof that the applicant is currently engaged in the practice of dentistry: (a) Dentists serving in the United States federal services as described in RCW 18.32.030(2) must provide documentation from their commanding officer regarding length of service, duties and responsibilities, and any adverse actions or restrictions; (b) Dentists employed by a dental school approved under WAC 246-817-110 (2)(a) must provide documentation from the dean or appropriate administrator of the institution regarding the length and terms of employment, duties and responsibilities, and any adverse actions or restrictions; (c) Dentists in a dental residency program must provide documentation from the director or appropriate administrator of the residency program regarding length of residency, duties and responsibilities, and any adverse actions or restrictions; or (d) Dentists practicing dentistry for a minimum of twenty hours per week for the four consecutive years preceding application	X	X	
West Virginia	X	\$180	Is a graduate of and has a diploma from a school accredited by the Commission on Dental Accreditation or equivalently approved dental college, school, or dental department of a university as determined by the board	Be licensed in good standing with another state			X
Wisconsin	X	\$60	(a) The applicant has graduated from an accredited school of dentistry or the applicant has graduated from a foreign dental school and holds one of the following: 1. A DDS or DMD degree from an accredited dental school. 2. A dental diploma, degree or certificate from a full-time, undergraduate supplemental dental education program of at least 2 academic years at an accredited dental school. The program shall provide didactic and clinical education to the level of a DDS or DMD degree.	Hold a good standing license	X		
Wyoming	X	\$750	who has graduated and attained the degree of doctor of dental surgery or doctor of dental medicine from a college or university in the United States or Canada accredited by the commission on dental accreditation of the American Dental Association	Active clinical practice of 1,000 hours in the last twelve (12) months			

<u>State</u>	<u>Experience Requirements</u>	<u>Degree Requirements</u>	<u>Exam Requirements</u>	<u>Other Requirements</u>
Florida	None	Credentials will be evaluated by World Educational Services or ECE to ensure education is equivalent of a US dental hygiene program	Pass the NBDHE, ADEX, and Jurisprudence	Proof of CPR Certification
Massachusetts	5 years	regulations/ application have not been created yet. Law just passed January 2025.	regulations/ application have not been created yet. Law just passed January 2025.	Training and Education requires a degree of competency determined by the Board.

Board of Medicine reduced the amount of years of clinical experience required for licensure by endorsement/credentialing/reciprocity

18VAC85-20-141 Licensure by endorsement

To be licensed by endorsement, an applicant shall:

1. Hold at least one current, ~~unrestricted~~ active license in a United States jurisdiction or Canada ~~for the five years immediately preceding application to the board;~~
2. Have been engaged in active practice, ~~defined as an average of 20 hours per week or 640 hours per year, for two out of the last five years after postgraduate training and~~ immediately preceding application, where such practice is not required to be consecutive;
3. Verify that the most recent license held in another United States jurisdiction or in Canada is in good standing, defined as current and unrestricted, or if lapsed, eligible for renewal or reinstatement;
4. Hold current certification by one of the following:
 - a. American Board of Medical Specialties;
 - b. Bureau of Osteopathic Specialists;
 - c. American Board of Foot and Ankle Surgery;
 - d. American Board of Podiatric Medicine;
 - e. Fellowship of Royal College of Physicians of Canada;
 - f. Fellowship of the Royal College of Surgeons of Canada; or
 - g. College of Family Physicians of Canada;
5. Submit a current report from the U.S. Department of Health and Human Services National Practitioner Data Bank; and
6. Have no grounds for denial based on provisions of § 54.1-2915 of the Code of Virginia or regulations of the board nor any disciplinary restrictions on a current, active license.



Virginia Department of
Health Professions
Board of Dentistry

**Current Law and regulations for Dentists seeking licensure through
endorsement/credentialing/reciprocity**

§ 54.1-2709. License; application; qualifications; examinations

B. An application for such license shall be made to the Board in writing and shall be accompanied by satisfactory proof that the applicant

(i) is of good moral character;

18VAC60-21-190. General application provisions.

3. A current report from the U.S. Department of Health and Human Services National Practitioner Data Bank (NPDB).

(ii) is a graduate of an accredited dental school or college, or dental department of an institution of higher education;

Regulations define education as the following:

18VAC60-21-190. General application provisions.

1. A final certified transcript from the college from which the applicant received the dental degree or post-doctoral degree or certificate as specified in **18VAC60-21-200**;

18VAC60-21-200. Education.

An applicant for unrestricted dental licensure shall be a graduate of and a holder of a diploma or a certificate from a dental program accredited by the Commission on Dental Accreditation of the American Dental Association or the Commission on Dental Accreditation of Canada, which consists of either a pre-doctoral dental education program or at least a 12-month post-doctoral advanced general dentistry program or a post-doctoral dental program of at least 24 months in any other specialty that includes a clinical component.

(iii) has passed all parts of the examination given by the Joint Commission on National Dental Examinations;



Virginia Department of
Health Professions
Board of Dentistry

(iv) has successfully completed a clinical examination acceptable to the Board; and

Dental Applications by Credentials/Endorsement

For dental applicants who apply for licensure by credentials, the Board will accept a passing score of the clinical competency exam required in the state in which the dentist was originally licensed. The Board will accept clinical exam components from one testing agency. The Board will not accept combined clinical exam components from more than one agency. The Board will not accept certificates or Canadian exams.

(v) has met other qualifications as determined in regulations promulgated by the Board.

C. The Board may grant a license to practice dentistry to an applicant licensed to practice in another jurisdiction if he

(i) meets the requirements of subsection B;

(ii) holds a current, unrestricted license to practice dentistry in another jurisdiction in the United States and is certified to be in good standing by each jurisdiction in which he currently holds or has held a license;

(iii) has not committed any act that would constitute grounds for denial as set forth in § 54.1-2706; and

(iv) has been in continuous clinical practice for five out of the six years immediately preceding application for licensure pursuant to this section. Active patient care in the dental corps of the United States Armed Forces, volunteer practice in a public health clinic, or practice in an intern or residency program may be accepted by the Board to satisfy this requirement.

18VAC60-21-210

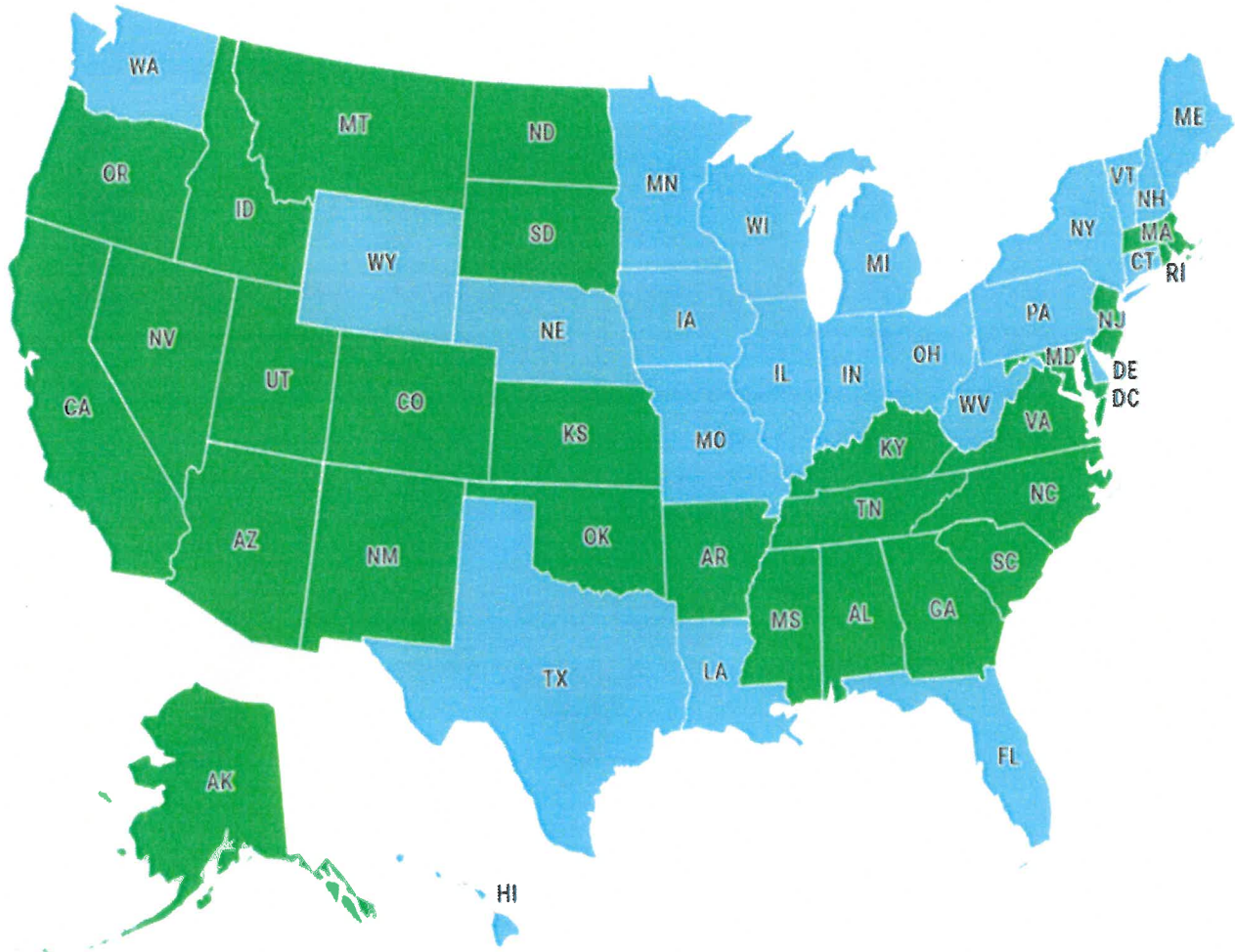
B. Dental licensure by credentials. All applicants for licensure by credentials shall:

4. Have been in continuous clinical practice in another jurisdiction of the United States or in federal civil or military service for five out of the six years immediately preceding application for licensure pursuant to this section. Active patient care in another jurisdiction of the United States (i) as a volunteer in a public health clinic, (ii) as an intern, or (iii) in a residency program may be accepted by the board to satisfy this requirement. One year of clinical practice shall consist of a minimum of 600 hours of practice in a calendar year as attested by the applicant.

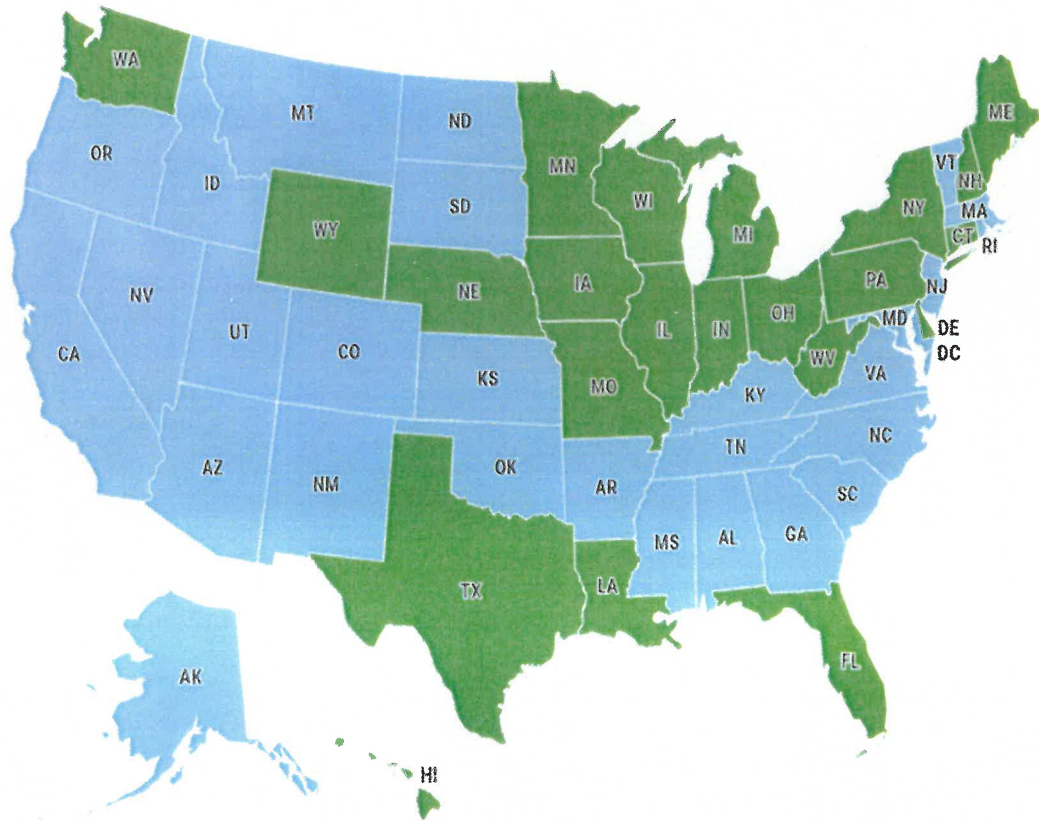


Virginia Department of
Health Professions
Board of Dentistry

There are **27 states** that have similar active practice requirements to Virginia



There **22 states** that have lower (or no requirements) of active practice than Virginia





Virginia Department of
Health Professions
Board of Dentistry

**Current Laws and Regulations for Dental Hygienists for
Endorsement/Credentialing/Reciprocity**

§ 54.1-2722. License; application; qualifications; practice of dental hygiene; report.

B. An application for such license shall be made to the Board in writing and shall be accompanied by satisfactory proof that the applicant

(i) is of good moral character,

18VAC60-25-130. General application requirements.

3. A current report from the U.S. Department of Health and Human Services National Practitioner Data Bank (NPDB).

(ii) is a graduate of a dental hygiene program accredited by the Commission on Dental Accreditation and offered by an accredited institution of higher education,

(iii) has passed the dental hygiene examination given by the Joint Commission on National Dental Examinations, and

(iv) has successfully completed a clinical examination acceptable to the Board.

Dental Hygiene Applications by Credentials/Endorsement

For dental hygiene applicants who apply for licensure by credentials, the Board will accept a passing score of the clinical competency exam required in the state in which the dental hygienist was originally licensed. The Board will accept clinical exam components from one testing agency. The Board will not accept combined clinical exam components from more than one agency. The Board will not accept certificates or Canadian exams.

C. The Board may grant a license to practice dental hygiene to an applicant licensed to practice in another jurisdiction if he

(i) meets the requirements of subsection B;

(ii) holds a current, unrestricted license to practice dental hygiene in another jurisdiction in the United States;

(iii) has not committed any act that would constitute grounds for denial as set forth in § 54.1-2706; and



Virginia Department of
Health Professions
Board of Dentistry

(iv) meets other qualifications as determined in regulations promulgated by the Board.

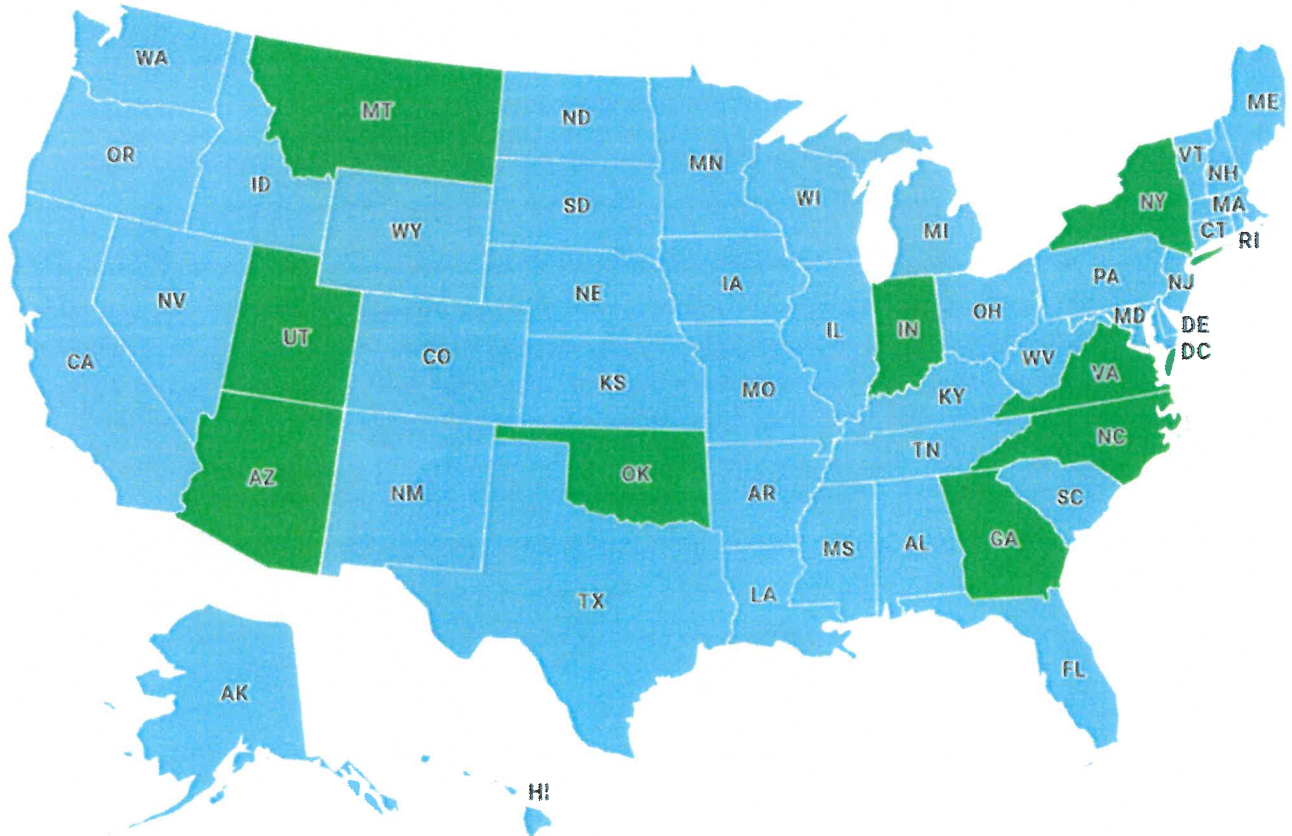
18VAC60-25-150. Licensure by credentials.

2. Be currently licensed to practice dental hygiene in another jurisdiction of the United States and have active clinical practice for 24 of the past 48 months immediately preceding application for licensure;



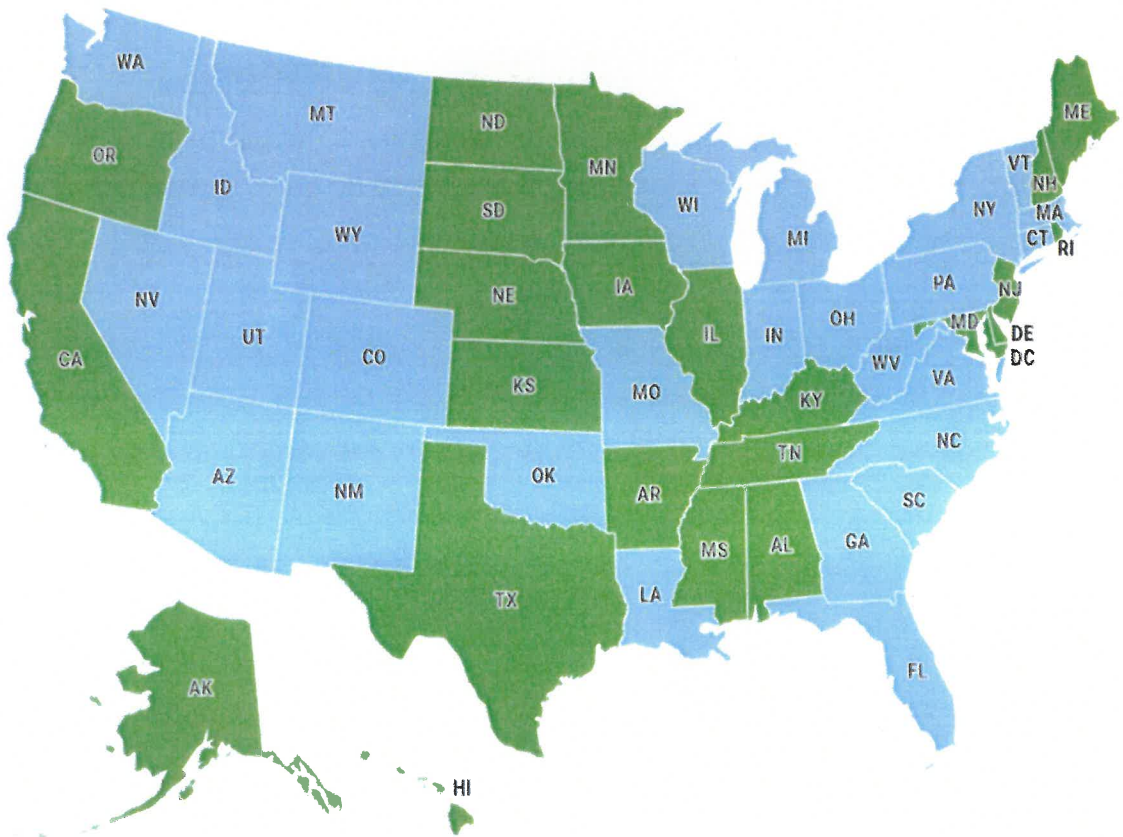
Virginia Department of
Health Professions
Board of Dentistry

Virginia has licensure by Endorsement/Credential/Reciprocity which requires clinical practice for 24 months out of the 48 months immediately preceding application for licensure
8 States have the same clinical practice requirements as Virginia



24 states have higher active practice requirements than Virginia

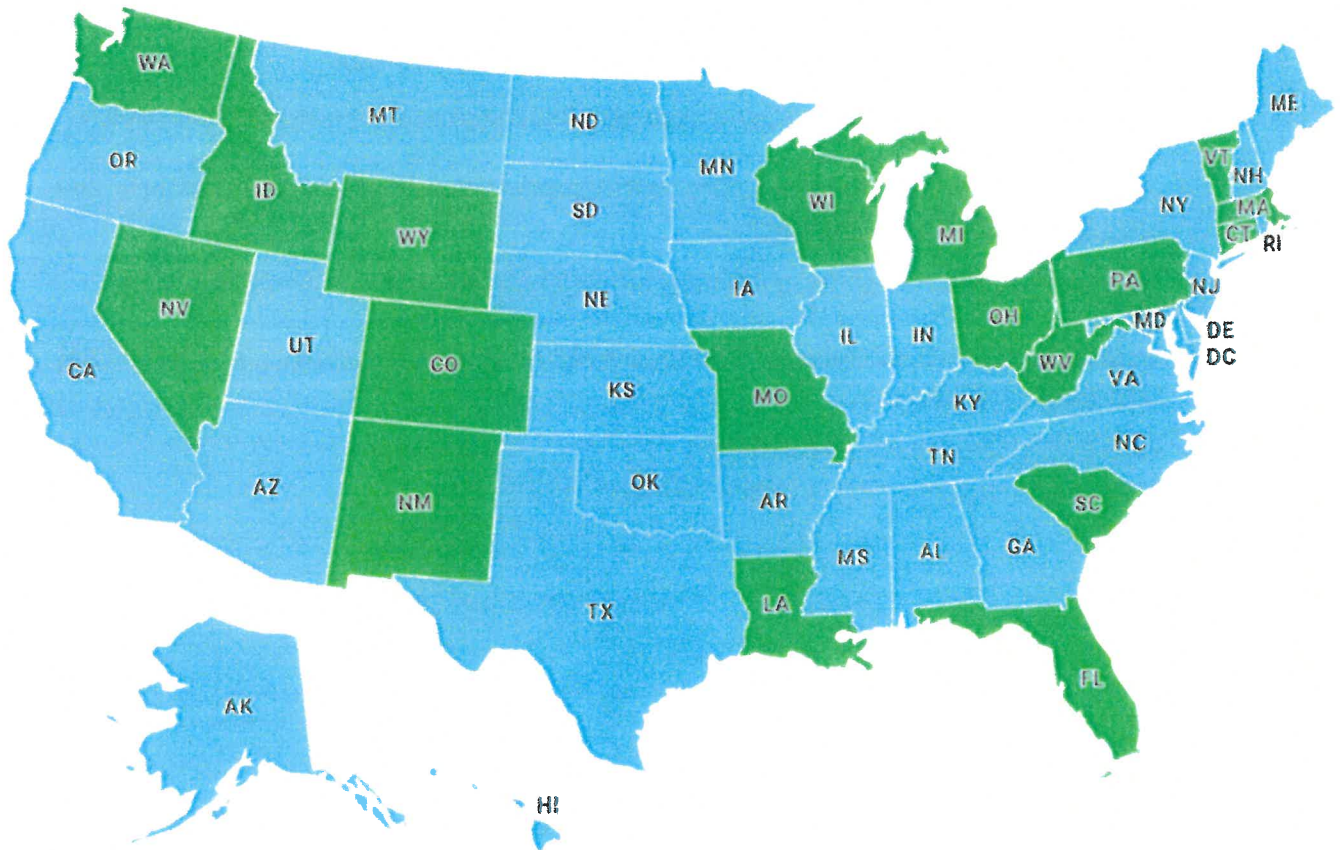
*this includes Washington, DC





Virginia Department of
Health Professions
Board of Dentistry

18 states have less active practice requirements than Virginia or no active practice requirements for endorsement/credentialing/reciprocity



Additional Resources for Consideration

- ADHA Position Statement (2 of them)
- Standards of DH Clinical Practice
- Curriculum of BS in Dental Hygiene
- New ADA Policies <https://adanews.ada.org/ada-news/2024/november/new-ada-policies-empower-states-to-alleviate-dental-workforce-shortage/#:~:text=Under%20514H%2D2024%2C%20the%20ADA,Dr.>
- ADHA Objection [https://www.adha.org/newsroom/adha-objects-to-ada-resolutions-calls-for-constructive-collaboration/#:~:text=The%20American%20Dental%20Association%20\(ADA,within%20dentistry%20and%20dental%20hygiene.](https://www.adha.org/newsroom/adha-objects-to-ada-resolutions-calls-for-constructive-collaboration/#:~:text=The%20American%20Dental%20Association%20(ADA,within%20dentistry%20and%20dental%20hygiene.)
- Legislation allows Foreign-Trained Dentist <https://dentalmanagerssociety.com/foreign-trained-dentists/#:~:text=On%20January%2010%2C%202025%2C%20new,obtain%20a%20dental%20hygiene%20license.>
- 2023 BOD Licensure Workgroup Report <https://rga.lis.virginia.gov/Published/2023/RD474/PDF>

POSITION STATEMENT

Dental Hygiene Workforce Shortage

The American Dental Hygienists' Association (ADHA®) recognizes the dental hygiene workforce shortage and supports appropriate strategies to retain and build the workforce.

As the largest organization advocating for the dental hygiene profession, the ADHA recognizes the workforce shortage of dental hygienists, dentists and other allied oral healthcare workers. An increase in the recruitment and retention of trained, educated, licensed professionals to restore and grow the oral healthcare workforce is needed.

In order to fully address the dental hygiene workforce shortage, it is critical to rely on data that have been collected from dental hygienists regarding their current and future needs. The 2022 research report, "[Dental Workforce Shortages: Data to Navigate Today's Labor Market](#)", produced through a collaboration between the ADHA, the American Dental Association (ADA) Health Policy Institute and other oral healthcare organizations, identified several chronic factors, beyond pandemic-related and retirement reasons, driving dental hygienists to leave the profession. The report revealed staff retention challenges citing inadequate benefits, non-responsive compensation, poor communication, lack of professional fulfillment and negative workplace culture as key contributing factors to workforce attrition.

While the ADHA does not support the [resolutions adopted in October 2024 by the American Dental Association \(ADA\)](#) concerning dental workforce shortages, we look forward to addressing the identified workforce-related issues in partnership with the ADA and other related dental professional organizations.

The ADHA supports addressing the issues that underlie workforce departures and enhancing recruitment into the profession as more appropriate strategies to retain and build the dental hygiene workforce. The ADHA is leading efforts to resolve dental hygiene workforce shortages through constructive measures. These include supporting and advising on the creation of additional entry-level dental hygiene programs and on the increase in capacity of current entry-level dental hygiene programs, where appropriate. The ADHA offers webinars and workshops on addressing workplace culture, leadership, professional empowerment and autonomy. Additionally, the ADHA is developing a [new chairside recruitment](#) program aimed at expanding the dental hygiene workforce. We encourage other dental professional organizations to address their specific workforce issues.

The ADHA recognizes the complexity of the situation and supports collaborating with other dental-related groups on fostering professional autonomy and empowering dental hygienists to work to their full scope of practice, which will lead to better health outcomes for the public and improve workplace culture.

POSITION STATEMENT

Dental Hygiene Education

The American Dental Hygienists' Association (ADHA®) opposes policies for alternative dental hygiene licensure pathways for non-hygienists.

The ADHA opposes any policies supporting dental students, residents, and foreign-trained dentists with an alternative pathway to obtain dental hygiene licensure and practice dental hygiene in the United States and increasing the faculty-to-student ratios in dental hygiene education programs.

Allowing those in roles that are complementary to dental hygiene to practice the profession without the same extensive dental hygiene education and practical training is harmful to patients and damaging to the standards of the dental hygiene profession.

U.S. dental hygiene education at programs accredited by the Commission on Dental Accreditation (CODA) is deeply comprehensive and includes significant faculty supervision for upholding the highest standards of dental hygiene practice. The curriculum for dentists dedicated to dental hygiene is not comparable.

The ADHA firmly believes that any individual seeking to practice dental hygiene in the U.S. must complete a CODA-accredited dental hygiene education program, and meet the clinical training, examination and practice requirements necessary to earn a dental hygiene license, without exception.

© American Dental Hygienists' Association, 2024

adha AMERICAN
DENTAL HYGIENISTS'
ASSOCIATION™

Standards For Clinical Dental Hygiene Practice

REVISED 2025



Brought to you by an unrestricted educational distribution grant by



Contents

REVISED MARCH 2025

STANDARDS FOR CLINICAL DENTAL HYGIENE PRACTICE

STANDARDS FOR CLINICAL DENTAL HYGIENE PRACTICE COMMITTEE

CONTENT EXPERTS

Beth Jordan, RDH, MS, FADHA

Karen Palleschi, RDH, BSDH, MS

Jennifer Pieren, RDH, BSAS, MS, FADHA

Ann Spolarich, RDH, PhD, FSCDH

Darlene J. Swigart, EPDH, MS, FADHA

Pamela Zarkowski, JD, MPH

BOARD ADVISOR

Sheri A. Moore, RDH, BSHS, FADHA

ADHA STAFF

JoAnn Gurenlian, RDH, MS, PhD,
AAFAAOM, FADHA

Kerrienne M. Aulet, CAP

History	3
Introduction	4
Assessment	5
Dental Hygiene Diagnosis	7
Planning	8
Implementation	9
Evaluation.	11
Documentation	13
References	14
Appendix A	15

History

One hallmark of a true profession is its willingness to assume responsibility for the quality of care that its members provide. In 1985, the American Dental Hygienists' Association (ADHA®) took a major step toward fulfillment of that responsibility with the development of the Applied Standards of Clinical Dental Hygiene Practice¹. This document is the fourth version to build on those standards and promote dental hygiene practice based on current and relevant scientific evidence.

Introduction

The ADHA Standards for Clinical Dental Hygiene Practice play a crucial role in maintaining consistency and quality within the profession. These standards serve as a framework guiding dental hygienists in delivering safe, ethical, and evidence-based care. They ensure that individuals receive comprehensive and effective treatment while promoting ongoing professional growth and accountability. Importantly, the standards are not a substitute for clinical judgment; rather, they complement the expertise of licensed professionals who are responsible for the care they provide.

Dental hygienists must be mindful of the legal obligations that come with their practice, as these standards must be applied in accordance with the laws of their specific jurisdictions. They are also expected to respect diverse values, health beliefs, and cultural practices, recognizing that each person brings unique perspectives to their care. By adhering to these guidelines, dental hygienists and the broader dental team ensure a shared understanding of professional expectations, which leads to better treatment planning, collaborative care and ultimately, improved patient outcomes.

This document, based on the 2016 revision of the ADHA Standards for Clinical Dental Hygiene Practice², further refines best practices in clinical settings, education, research, and public health, helping to uphold the integrity of the dental hygiene profession.

Assessment Standards

Assessment includes the identification of risk factors that may influence outcomes, alter the person's ability to withstand treatment, and/or increase the likelihood of a medical emergency. The frequency of a comprehensive health/oral health assessment is based on the individual's presentation, response to treatment, adherence to recommendations, and frequency of continuing care. Assessment is an ongoing process and includes both health history and clinical assessment data.

I. Health History

A health history assessment includes multiple data points that are collected through a written document and an oral interview. The process helps build a rapport with the individual and verifies key elements of health status. Information is collected and discussed in a location that ensures privacy and complies with the Health Insurance Portability and Accountability Act (HIPAA).³

Demographic information is any information that is required for healthcare purposes. It includes but is not limited to: address, date of birth, emergency contact information, email, phone numbers, and the names and contact information for the referring/previous dentist, all physicians of record, and preferred pharmacy.

A comprehensive health history assessment includes a review of systemic health status, mental health status, known allergies, over-the-counter and prescription medication use, date of last physical examination and blood tests, substance use, and vital signs.

II. Systemic Diseases/Conditions

Medical history is the documentation of overall systemic health. This information can identify the need for physician consultation or any contraindications for treatment. This would include mental health, cognitive impairments, behavioral disorders, disabilities, and functional capacity. Clinicians should assess the person's ability to withstand treatment (e.g. appointment length) as well as the need for modifications (e.g. modified positioning, need for antibiotic prophylaxis, need for stress reduction protocol, use of a quiet room, etc.). Laboratory tests such as A1c, INR, glucose levels, CBC, platelets, and absolute neutrophil count may need to be requested to guide treatment planning. Liver and kidney function should be assessed if administering medications and local anesthetics during the dental hygiene process of care.

Pharmacologic history includes the list of medications, including dose and frequency, which the individual is currently taking. This includes, but is not limited to, over-the-counter (OTC) drugs or products such as vitamins, herbal and dietary supplements, and pre-/probiotics. The practitioner should confirm any history of or current adverse drug reactions, including allergy, systemic and oral side effects, abnormal responses to medications, and risk for drug interactions.

Vital signs, including height, weight, temperature, pulse, respiration, and blood pressure, provide a baseline of known conditions or help identify potential or undiagnosed health conditions.

Social history information such as relationship status, children, occupation, cultural practices, and other beliefs, might affect health or influence treatment acceptance. In addition, the following risk behaviors that impact health should be assessed, including tobacco, alcohol, and prescription drug misuse; recreational drug use and vaping; a history of substance use disorders; and sexual history.

III. Clinical Assessment

Planning and providing optimal care require a thorough and systematic clinical assessment. Assessment begins by physically observing the person, noting pallor, gait, orientation to time and place, mood, use of assistive devices to support ambulation, ability to and preferences for communication, presence of sensory impairments (e.g., vision and hearing), general appearance, and hygiene. Additional components of this assessment include a comprehensive examination of the head and neck and oral cavity, skin integrity, swallowing ability, and assessment of the temporomandibular joints. Documentation should include normal and abnormal findings and need for further evaluation.

A current, complete, and diagnostic set of radiographs provides needed data for a comprehensive dental, periodontal, and pathology assessment, and formation of dental hygiene diagnoses. The type and frequency of radiographs needed are based on observations from the clinical examination and thorough risk assessment and evaluation. Radiographs should be assessed for quality, the need for retakes and additional imaging based on the ALARA principle.⁴

A comprehensive periodontal examination is part of the clinical assessment and includes a full-mouth periodontal charting:

1. Probing depths
2. Bleeding points
3. Suppuration
4. Mucogingival relationships/defects
5. Recession
6. Attachment level/loss
7. Bone height/bone loss
8. Mobility and fremitus
9. Furcation involvement
10. Tooth loss
11. Biofilm and calculus deposits
12. Smoking, diabetes and A1c

Data gathered are used to assess gingival and periodontal health status, including health, gingivitis, staging and grading of periodontitis, and implant disease.

A comprehensive hard-tissue evaluation should be performed that includes the charting of existing conditions and oral habits using intraoral photographs, radiographs and advanced technology to supplement data. These data include:

1. Missing teeth
2. Primary, mixed or permanent dentition
3. Demineralization
4. Caries and recurrent decay
5. Defects and anomalies
6. Sealants
7. Existing restorations
8. Implants
9. Occlusion
10. Fixed and removable prosthesis retained by natural teeth or implant abutments

Additional evaluation includes the identification of hard and soft tissue pathologies that may require the need for referral and further evaluation. Examples include:

1. Periapical pathology
2. Bony growths and lesions
3. Abscesses
4. Ulcerations and alterations in mucosal integrity
5. Soft tissue swelling or tumor formation
6. Presence of bacterial, viral, and/or fungal infection
7. Salivary gland abnormalities/dysfunction
8. Trauma
9. Oral malodor
10. Craniofacial abnormalities
11. Neuralgias
12. Oral manifestations of malnutrition

IV. Risk Assessment

Risk assessment is a qualitative and quantitative evaluation based on health history and clinical assessment to identify any risk to general and oral health. Data provides the clinician with information to develop and design strategies for preventing or limiting disease, and promoting health. The level of risk should be identified and documented (extremely high, high, moderate, low). Examples of factors that should be evaluated include, but are not limited to, health behaviors, social determinants of health, and other risk factors that can influence oral health.

A comprehensive evaluation of the individual's health behaviors should be performed, including:

1. Health/oral health literacy
2. Physical activity/functional capacity
3. Diet
4. Sleep
5. Sexual activity
6. Social support
7. Health screening examinations
8. Alcohol, tobacco, vaping, and recreational drug use; history of substance use disorder
9. Health care seeking behaviors
10. Adherence to prescribed medical treatments
11. Self-care practices
12. Cultural practices and beliefs relevant to oral health
13. Dental history
14. Oral product use

A comprehensive evaluation of social determinants of health should be conducted, including:

1. Socioeconomic status
2. Housing
3. Education
4. Work/employment
5. Culture
6. Race/ethnicity inequalities
7. Environmental factors/physical safety
8. Access to nutritious foods/food insecurity
9. Insufficient access to affordable health and dental care
10. Limited community resources
11. Childcare concerns
12. Social support
13. Financial concerns
14. Stress
15. Transportation

Other risk factors to be identified include:

1. Fluoride exposure
2. Demographics (age, gender, genetics, family history)
3. Disability and special health care needs
4. Sleep apnea
5. Systemic diseases/conditions
6. Bleeding
7. Salivary function and xerostomia

8. Behavioral health/mental health disorders
9. Physical and emotional safety (domestic violence, physical, emotional, or sexual abuse, neglect, human trafficking)
10. Oral habits

Dental Hygiene Diagnosis (DHDx) Standards

The ADHA defines dental hygiene diagnosis as the identification of an individual's health behaviors, attitudes, and oral health care needs for which a dental hygienist is educationally qualified and licensed to provide.⁵ The ultimate goals of dental hygiene practice and care provided are to maintain health and prevent disease. By recognizing and addressing dental hygiene diagnoses, dental hygienists have the opportunity for early intervention and prevention.⁶

Dental hygiene diagnosis/diagnoses (DHDx) involve critically evaluating the individual's assessment information collected through written health history, oral interview, and clinical assessment.⁶ Full assessment data includes factors pertaining to an individual's health/medical history, vital signs, physical characteristics, social history, pharmacologic history, comprehensive periodontal evaluation, hard-tissue evaluation, hard and soft tissue pathologies, risk assessments for health behaviors, social determinants of health^{7,8}, signs and symptoms of disease, and other specific risk factors relevant for that person. For person-centered care that is specific for each individual, the person's needs, values, and preferences must be considered when formulating the DHDx.^{9,10}

The dental hygienist analyzes assessment data to determine hindrances to optimal oral and systemic health outcomes. The dental hygienist then determines each DHDx and correlates contributing factors pertaining to each diagnosis. Dental

hygiene diagnostic statements are formulated. These DHDx will direct the dental hygiene care plan to ensure all needs are addressed.^{6,11-13} Elements in the care plan based on the DHDx include education, self-care practices, prevention strategies, treatment, evaluation, counseling, and referral needs.¹¹⁻¹³

Individuals need to be given the opportunity to understand their specific health problems/DHDx in order to make the best decisions for their health.⁹

Categories for DHDx include:

1. Systemic health factors
2. Behavioral health factors
3. Social determinants of health factors
4. Periodontal disease classification
5. Hard and soft tissue conditions
6. Individual needs, values and preferences

The process of DHDx involves the following steps:

1. Analyze and interpret all assessment data.
2. Formulate the dental hygiene diagnoses.
3. Determine the person's needs that can be improved through the delivery of dental hygiene care.
4. Identify referrals needed within dentistry and other health care disciplines based on DHDx.
5. Communicate the DHDx with the individual to engage the person in formulating their dental hygiene care plan.
6. Document the DHDx and follow-up at future appointments to determine the status of these diagnoses.

A comprehensive DHDx includes multiple diagnoses for each person.¹¹⁻¹³ DHDx should be determined for individuals and community groups.

Planning Standards

Planning is the process by which diagnosed person-centered needs are prioritized, goals and evaluative measures are established, intervention strategies are determined, and an appointment schedule is proposed.⁶ The purpose of the dental hygiene care plan is to develop a strategy of care that results in the resolution of an oral health problem amenable to dental hygiene care, the prevention of a problem, or the promotion of oral health and well-being.⁶ A formal, written dental hygiene care plan is based on sound clinical decision-making and reflects evidence-based best practices. Depending on the workforce model and state practice law, the written care plan may support direct payment for dental hygiene services.

In a traditional clinician-dentist practice model, the dental hygiene care plan is part of and supports the overall dental treatment plan. A similar coordination of care occurs in a collaborative agreement relationship between the dental hygienist and dentist in a teledentistry workforce model. In a medical-dental integrated workforce model, the dental hygiene care plan may be a collaboration with an interdisciplinary care team. However, a dental hygienist providing direct care without dental supervision or collaboration will formulate a stand-alone dental hygiene care plan based upon the assessment and dental hygiene diagnosis, implement the plan, and refer the individual for needed dental care or primary healthcare services.⁵ When medical or dental needs are urgent, the dental hygienist will refer the individual prior to or in conjunction with dental hygiene services.¹⁴ In all workforce models, the dental hygienist will make care planning decisions in accordance

with legal, professional and ethical principles. The dental hygienist will continue to collaborate with the dentist and interdisciplinary health care providers for optimal person-centered care.

The dental hygiene care plan is written following Dental Hygiene Diagnosis. The dental hygiene diagnosis serves as the foundation for formulating a person-centered dental hygiene care plan. In collaboration with the dentist and/or interdisciplinary care team, the dental hygienist considers each discipline's diagnoses and determines their urgency. Dental hygiene diagnoses are prioritized by considering those that threaten the well-being of the individual, may be addressed simultaneously with other diagnoses, and are a priority or chief concern of the individual.⁶ To assure that the person's comprehensive diagnosed needs are addressed, the dental hygiene care plan is sequentially developed and linked to the dental hygiene diagnoses. Linking the care plan to the dental hygiene diagnoses is crucial to its development. The dental hygiene care plan specifies the following:

- Goals and evaluative measures
- Dental hygiene interventions
- Appointment schedule

The dental hygiene care plan should identify a cohesive relationship between the dental hygiene diagnoses, goals and intervention strategies. The individual's psychosociocultural and physical needs as well as readiness for change must be supported by the care plan.

I. Goals and Evaluative Measures

A care plan goal is the desired outcome to be achieved through specific dental hygiene intervention strategies to satisfy an identified need or problem.² Care plan goals establish a framework that defines the expectation of the person, that is, their desired health outcome and self-responsibilities for goal attainment. A well written care plan goal states the⁶ :

- person responsible for achieving the goal, that is, the individual or caregiver;
- desired action of the person and/or caregiver specifying how the goal will be measured;

- criterion for measurement, that is, the desired observable behavior or tangible outcome;
- time frame for when the individual is to achieve the goal.

In a guided discussion with the individual and/or caregiver, the dental hygienist will define one or more goals for each dental hygiene diagnosis. The dental hygienist will consider both clinical and behavioral or person-centered goals.

- Clinical goals address oral health status needs and are defined by the specific signs and symptoms or evidence of the identified oral health problem/need or risk of a condition/problem.
- Person-centered goals address cognitive, psychomotor and affective behaviors. They are defined by contributing factors of the identified oral health problem/need or risk of a condition or problem.

Including both clinical and person-centered goals emphasizes a clinician-person team approach to attaining desired oral health outcomes and communicates the importance of the individual's or caregiver's role in achieving and maintaining oral health.

II. Intervention strategies

Dental hygiene interventions are evidence-based strategies that, when applied, reduce, eliminate or prevent a diagnosed problem or need.⁶ Intervention strategies are selected to address the etiology or underlying contributors to a diagnosed condition or problem, such as identified barriers preventing the person from achieving positive oral health outcomes. Preventive, educational, therapeutic, and supportive counseling, and inter- and intra-disciplinary referrals within the scope of dental hygiene practice are considered. The dental hygienist will select strategies that reflect evidence-based, clinically sound, equitable care to support the attainment of the care plan goals or desired care plan outcomes. Selecting intervention strategies tailored to address a person's unique needs increases the likelihood that care plan goals will be achieved.

III. Appointment Schedule

An appointment schedule is planned for implementing the dental hygiene intervention strategies. The schedule will guide the clinician and the individual through the implementation of planned care. The dental hygienist considers the:

- number of visits (preventive or wellness visit, complex multiple therapeutic visits, supportive periodontal maintenance visit);
- time needed for each visit (pain management, patient management, planned services, evaluation of goals or patient outcomes);
- interventions to be implemented at each visit;
- integration of educational interventions and sequencing small increments of oral self-care strategies into each visit.

The dental hygienist will determine the sequencing and length of each appointment in accordance with the complexity of planned individual needs.

IV. Care Plan Presentation and Consent

Presentation of the dental hygiene diagnoses and dental hygiene care plan is best accomplished by establishing a collaborative, co-therapeutic relationship with the individual and/or caregiver. The dental hygienist will ask open-ended questions to encourage active dialogue for shared decision-making. Presentation of the care plan should include the⁶:

- nature of the condition
- proposed care plan, rationale, and number of appointments
- alternative evidence-based treatment options, when available
- risks involved, if any
- potential for failure
- prognosis if the problem goes untreated
- individual's questions are answered

The dental hygienist will obtain and document consent from the individual and/or guardian prior to the implementation of the planned services. The dental hygienist will assure that the individual has the information needed to make an informed decision, specifically informed consent and/or informed refusal.

Implementation Standards

Implementation is the actual process of carrying out the dental hygiene care plan. The implementation phase involves actively incorporating evidence-based research and guidelines to ensure safe and effective care while engaging the individual as a co-therapist. As a primary oral health care provider, the dental hygienist delivers dental hygiene services based on the care plan, including any required modifications, while minimizing risk and optimizing oral and systemic health.^{5,6}

Person-centered care is essential throughout the implementation process. The dental hygienist should consider the individual's unique needs, preferences, and values when selecting and delivering interventions. Culturally sensitive care and culturally sensitive communication are vital to establish trust, build rapport, and ensure effective communication. Additionally, appropriate technology and diagnostics for monitoring, management, and treatment of diseases can enhance the implementation process, but they must be evidence-based and used ethically and responsibly, prioritizing individual privacy and confidentiality.^{6,14}

Depending on the number of interventions, the dental hygiene care plan may be implemented in one preventive/wellness visit or several therapeutic visits before a continuing or maintenance plan is established. Health promotion and

self-care education are integral aspects of the care plan that should be customized and implemented according to the individual's interest and ability.^{5,6,14}

Key steps involved in the implementation phase include:

1. Review and confirm the dental hygiene care plan:
 - Ensure mutual understanding with the individual or caregiver
 - Address any questions or concerns
2. Modify the plan as necessary, ensure mutual understanding, obtain informed consent if necessary:
 - Reassess the individual's needs and adjust the plan accordingly
 - Consider any changes in the person's health status or circumstances
3. Implement the plan:
 - Prioritize evidence-based interventions on the individual's needs and urgency
 - Deliver services in a timely and efficient manner
 - Monitor the individual's comfort throughout the process
4. Provide post-treatment instructions:
 - Educate the individual on evidence-based oral hygiene practices (e.g., toothbrushing for two minutes twice daily) and products (antiseptic mouthrinses, antimicrobial toothpaste, electric rechargeable toothbrushes), dietary recommendations (reduce intake of ultraprocessed foods, sugar-sweetened beverages, processed meats, and refined grains), and topical or systemic medication usage (prescription strength fluoride, topical fluorides, other re-mineralization agents, and dentin hypersensitivity agents) as needed
 - Address any concerns or questions
5. Implement self-care interventions:
 - Implement the appropriate self-care interventions. Tailor self-care recommendations to the individual's specific needs and abilities
 - Educate and encourage participation in self-care activities by using evidence-based strategies to motivate and empower the individual to take ownership of their oral health
6. Confirm the plan for continuing care or maintenance:
 - Adapt as necessary throughout future interventions
 - Schedule follow-up appointments as needed
 - Develop a long-term care plan to maintain oral health including routine screenings for early detection
 - Coordinate with other healthcare providers as necessary. This may involve referrals to dental specialists, such as periodontists or oral surgeons, or collaboration with primary care physicians to address systemic health concerns
7. Maintain patient privacy and confidentiality:
 - Adhere to HIPAA regulations and professional ethics to protect information from unauthorized access
8. Follow-up as necessary:
 - Monitor the individual's progress and address issues by making modifications
 - Provide additional support, education, pain management, or referral as needed
 - Emphasize the importance of continuing care for maintaining optimal oral health

Evaluation Standards

Evaluation is the measurement of the extent to which the person has achieved the goals specified in the dental hygiene care plan, that is, fulfillment of the person's diagnosed needs, values and preferences that impact care.⁵ Integrating evaluation into person-centered care fulfills the dental

hygienist's ethical and legal responsibility that planned and implemented dental hygiene care is moving the person toward achieving positive care outcomes.⁵ Evaluation is a continuous process of ongoing monitoring and interpretation of the effectiveness of the dental hygiene care provided. The dental hygienist uses evidence to continue, discontinue, or modify the care plan. The individual's reported outcomes (patient-reported outcome measures) are used to capture their perspective about their health status, symptoms and ability to function, including how well the treatment has worked from their viewpoint. Further, this information supports evaluation about how the individual's oral health status impacts their quality of life, a metric which can be overlooked by using only clinical measures. Reported outcome measures are used to guide shared decision-making for continued care, which leads to more informed treatment decisions.

Elements of evaluation are integrated into each Standard to support person-centered care, as follows⁶:

- **Assess and Dental Hygiene Diagnosis.** The dental hygienist collects and analyzes assessment findings to establish individual needs. The identified needs guide the dental hygienist to formulate the dental hygiene diagnostic statements and provide the foundation for developing evaluation strategies.
- **Plan.** The dental hygienist, in collaboration with the individual, formulates care plan goals, that is, evaluation measures and methodology as defined by the dental hygiene diagnostic statements. The dental hygiene care plan suggests a timeline for goal achievement.
- **Implement.** Throughout the implementation of planned interventions, the dental hygienist continually monitors the person's progress toward goal achievement. The dental hygienist uses periodic reassessment to collect, interpret and conclude when care plan strategies are moving the individual toward attaining desired health outcomes or when modifications to the care plan are needed. The dental hygienist shares findings with the individual and documents progress made in the person's dental hygiene record.
- **Evaluate and Document.** At the completion of the dental hygiene care plan, the dental hygienist measures the individual's response to treatment. An evaluative

statement is documented that includes the attainment of care plan goals to determine the person's prognosis for continued health, recommendations for a supportive continued cycle of care, and referrals made for additional services, as needed. To evaluate the care plan goals, the dental hygienist selects measurable assessment criteria that reflect the intent of the goal being measured such as cognitive, psychomotor, affective or clinical. The dental hygienist uses critical thinking to analyze the findings and draw conclusions to the extent of goal attainment.

At subsequent cycles of care or continued care appointments, the dental hygienist applies reassessment strategies to measure long term success at achieving or maintaining the resolution of a need or problem addressed by the previous care plan. The dental hygienist will apply the new assessment findings against the previous care plan goals to determine the extent to which the goals continue to be met. When there is a recurrence of a condition or new condition, the dental hygienist will further investigate to determine the underlying contributor. The process of care then continues.

Evaluation of individual care outcomes communicates critical and necessary feedback to the dental hygienist, individual, dentist and interdisciplinary care providers.

- To the individual, awareness that self-responsibility for oral self-care and a commitment to a supportive continued care schedule is critical to achieving and maintaining oral health;
- To the dental hygienist, understanding the individual's satisfaction of the care provided, obtained through an oral or written questionnaire, influences shared decision-making and strengthens the individual's commitment to care;
- To the dental hygienist, self-evaluation is used throughout the process of providing care and identifying opportunities for quality improvement;
- To the dental hygienist, dentist, individual, and interdisciplinary team, collaboration helps to determine the need for additional diagnostic, treatment, referral, education, counseling (e.g., dietary and tobacco cessation), and continuing care based on treatment outcomes and self-care behaviors.

Documentation Standards

The goals of documentation are to maintain continuity of care, provide a means of communication among the individual's interdisciplinary care providers and minimize practitioners' risk of exposure to malpractice litigation. The individual's dental hygiene record represents an ethical and legal account of care provided. At the completion of each person's encounter, the provider will make an entry to the dental hygiene record detailing the events of the appointment. Documentation should establish a link between assessment, dental hygiene diagnosis, care planning, implementation of planned strategies and evaluation. Entries must be detailed enough to show how the individual progressed through each phase of care. These actions establish a chronological account of care provided and evidence to support a person-centered process of care.

Documentation is a complete and accurate recording of all collected data, diagnosed needs, individual involvement in care planning, consent for treatment, implementation of planned services and monitoring of progress, evaluation of treatment outcomes, prognosis, continued care recommendations, related communication and other interactions and information relevant to care provided.⁵

Entries into the dental hygiene record must:

- Be objective, concise, legible and accurate;
- Ensure that common terminology, abbreviations, acronyms are universal and may be easily understood by subsequent providers;

- Be written by the provider who performed the service, signed and dated (month/day/year);
- Include all information and interactions between the individual or caregiver and the practice (e.g., communications, emergencies, prescriptions, referrals) including failure to return for treatment or follow through with recommendations, with date and time (when relevant) of the interaction;
- Include informed consent with signature and date, and when indicated, informed refusal detailing steps taken to assure individual's or caregiver's understanding of their decision and risk of no treatment;
- Not be erased once saved. When there is an error in previously stored electronic information, the provider will mark the entry as mistaken, add correct information, and date and initial the entry.

Documenting entries to a person's electronic health record (EHR) makes needed care information available to the interprofessional healthcare providers for coordination and communication of services.⁶ Providers must:

- Comply with state regulations and statutes for recordkeeping and storage;
- Ensure compliance with the Federal Health Information Portability and Accountability Act (HIPAA) including electronic communication to protect confidentiality and security of documentation;
- Respect and protect the confidentiality of the person's information;
- Complete periodic monitoring of dental hygiene records to ensure that documentation adheres to legal and ethical standards of care.

Conclusion

The Standards for Clinical Dental Hygiene Practice serve as a vital resource for dental hygienists committed to delivering person-centered, evidence-based care. They underscore the importance of continuous professional growth to ensure ongoing competence and adaptability in a dynamic healthcare landscape. These standards will continue to evolve in response to advancements in scientific research, changes in ADHA policies, updates to federal and state regulations, and shifts in disease trends. By adhering to these standards, dental hygienists can confidently provide safe, high-quality care, meeting the ever-changing needs of their patients and the profession.

Keywords

ALARA – As Low as Reasonably Achievable referring to avoiding exposure to radiation that does not have a direct benefit to the individual, even if the dose is small.⁴

Evidence-Based Practice – the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individuals. The practice of evidence-based dental hygiene requires the integration of individual clinical expertise and an individual's preferences with the best available external clinical evidence from systematic research.⁵

Health Insurance Portability and Accountability Act (HIPAA) – a federal law that sets a national standard to protect medical records and other personal health information.³

Informed Consent – a process of providing an individual with the information needed to make a decision about treatment.⁶

Informed Refusal – documentation that an individual declines all or part of a proposed care plan.⁶

Person-Centered Care – integrated health care services delivered in a setting and manner that is responsive to individuals and their goals, values and preferences, in a system that supports good provider-individual communication and empowers individuals receiving care and providers to make effective care plans together.¹⁵

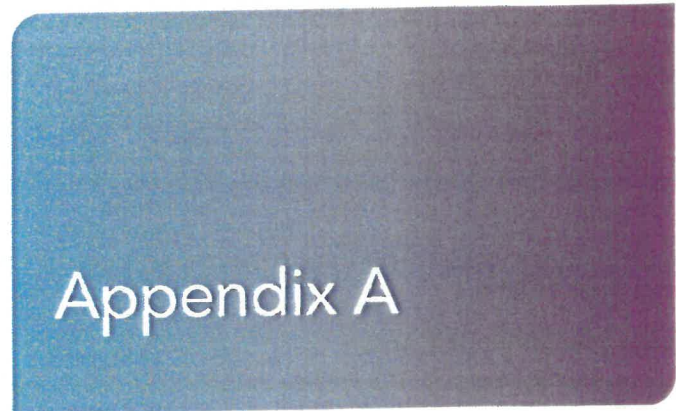
Social Determinants of Health – the non-medical factors that influence health outcomes including conditions in which individuals are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life.¹⁶

Supportive Continued Cycle of Care – a system designed to organize and maintain an appropriate schedule of dental hygiene care for each individual based on their needs; also referred to as continuing care, continued-care intervals, or recare.⁶

References

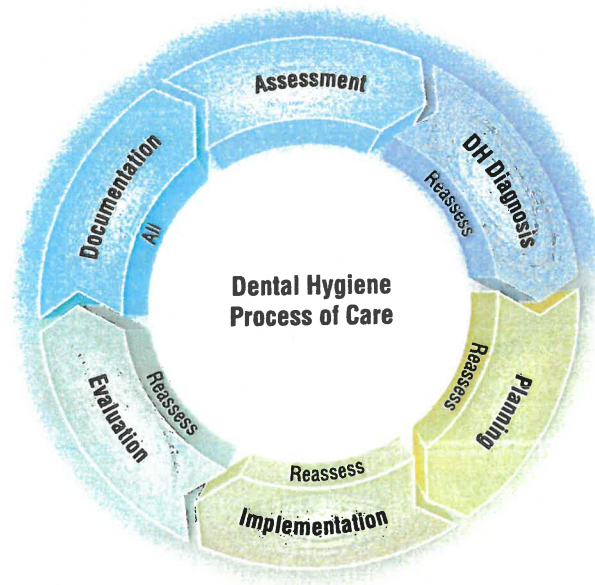
1. Standard of Applied Dental Hygiene Practice. Chicago: American Dental Hygienists' Association. 1985.
2. American Dental Hygienists' Association (ADHA). Standards for Clinical Dental Hygiene Practice. Revised 2016. Access. 2016 (suppl):1-15.
3. Centers for Disease Control and Prevention. Health insurance portability and accountability act of 1996 (HIPAA). 2024. Available at: <https://cdc.gov/phlp/php/resources/health-insurance-portability-and-accountability-act-of-1996-HIPAA.html>. Accessed December 10, 2024.
4. Centers for Disease Control and Prevention. Guidelines for ALARA- As low as reasonably achievable. 2024. Available at: <https://cdc.gov/radiation-health/safety/alara.html#>. Accessed December 10, 2024.
5. ADHA Policy Manual. American Dental Hygienists' Association [internet]. 2024. [cited 2024 Sept 27]. Available from: <https://www.adha.org/about-adha/policies-bylaws/>
6. Pieren, JA & Gadbury-Amyot, C. (2025). Darby & Walsh dental hygiene theory and practice (6th ed.). Elsevier.
7. Tellez, M., Zini, A. & Estupiñan-Day, S. Social determinants and oral health: An update. *Curr Oral Health Rep.* 2014 June 1, 148–152. <https://doi.org/10.1007/s40496-014-0019-6>

8. Mays KA, Cooper A, Wang Q. Bridging the health gap: Measuring the unmet social needs of patients within a dental school clinic. *J Dent Educ.* 2023 Aug 87(8):1099-1107. doi: 10.1002/jdd.13238.
9. Committee on Diagnostic Error in Health Care; Board on Health Care Services; Institute of Medicine; The National Academies of Sciences, Engineering, and Medicine; Balogh EP, Miller BT, Ball JR, editors. *Improving diagnosis in health care.* Washington (DC): National Academies Press (US). 2015. 472p. DOI: <https://doi.org/10.17226/21794>
10. Walji MF, Karimbux NY, Spielman AI. Person-centered care: Opportunities and challenges for academic dental institutions and programs. *J Dent Ed.* 2017 Nov;81(11):1265–1272. doi:10.21815/ JDE.017.084. PMID: 29093139.
11. Gurenlian, J. & Swigart, D. Components of dental hygiene diagnosis. *Dimensions Dental Hygiene.* 2018 Dec; 16(12), 36-39.
12. Swigart DJ, Gurenlian JR. Implementing dental hygiene diagnosis into practice. *Dimensions of Dental Hygiene.* 2015 Sept;13(9):56–59 [cited 2019 Dec 17]. Available from: [https:// dimensionsofdentalhygiene.com/article/implementing-dentalhygiene-diagnosis-into-practice/](https://dimensionsofdentalhygiene.com/article/implementing-dentalhygiene-diagnosis-into-practice/)
13. ADHA. Dental hygiene diagnosis: An ADHA white paper [Internet]. Chicago: American Dental Hygienists' Association; 2016. Available from https://www.adha.org/wp-content/uploads/2023/01/ADHA_White_Paper_Dental_Hygiene_Diagnosis_2016-08-22.pdf
14. ADHA Bylaws & Codes of Ethics. American Dental Hygienists' Association (internet) 2024. Available from: https://www.adha.org/wp-content/uploads/2024/07/adha_Bylaws_Codeof-ethics_FY24.pdf
15. Centers for Medicare & Medicaid Services. Person-centered care. CMS.gov. Available at: [cms.gov/priorities/innovation/key-concepts/person-centered care](https://www.cms.gov/priorities/innovation/key-concepts/person-centered-care). Accessed December 10, 2024.
16. World Health Organization. Social determinants of health. 2024. Available at: https://who.int/health-topics-social-determinants-of-health#tab=tab_1. Accessed December 10, 2024.



DENTAL HYGIENE PROCESS OF CARE⁶

There are six components to the dental hygiene process of care. These include: assessment, dental hygiene diagnosis, planning, implementation, evaluation, and documentation. The six components provide a framework for person-centered care activities.



Permission granted for reproduction of figure, from Chapter 1: The Dental Hygiene Profession. Darby and Walsh Dental Hygiene Theory and Practice. ISBN 9780323877824.

DENTAL HYGIENE, BACHELOR OF SCIENCE (B.S.)

The Bachelor of Science in Dental Hygiene requires two years of liberal arts study, with a minimum of 60 semester hours, followed by two years of study focusing on basic and dental sciences, dental hygiene science and theory, community health and pre-clinical and clinical experiences. Upon successful completion of the program, graduates are eligible for national, regional and state board licensing examinations. Classes enter once each year in the fall semester.

Student learning outcomes

Upon completing this program, students will know and know how to do the following:

Allied Dental Core Competencies Professional Knowledge

1. Professionalism

- 1.1 Apply professional values and ethics in all endeavors.
- 1.2 Adhere to accreditation standards and federal, state and local laws and regulations.
- 1.3 Promote quality assurance practices based on accepted standards of care.
- 1.4 Demonstrate interpersonal skills to effectively communicate and collaborate with professionals and patients across socioeconomic and cultural backgrounds.

2. Safety

- 2.1 Comply with local, state and federal regulations concerning infection control protocols for blood-borne and respiratory pathogens, other infectious diseases and hazardous materials.
- 2.2 Follow manufacturers' recommendations related to materials and equipment used in practice.
- 2.3 Establish and enforce mechanisms to ensure the management of emergencies.
- 2.4 Use security guidelines and compliance training to create and maintain a safe, eco friendly and sustainable practice compatible with emerging trends.
- 2.5 Ensure a humanistic approach to care.
- 2.6 Uphold a respectful and emotionally safe environment for patients and practitioners.

3. Critical Thinking

- 3.1 Demonstrate critical and analytical reasoning to identify and develop comprehensive oral health care solutions and protocols.
- 3.2 Apply individual and population risk factors, social determinants of health and

scientific research to promote improved health and enhanced quality of life.

4. Scientific Inquiry and Research

- 4.1 Support research activities and develop research skills.
- 4.2 Use evidence-based decision-making to evaluate and implement health care strategies aligned with emerging trends to achieve high-quality, cost-effective and humanistic care.
- 4.3 Integrate accepted scientific theories and research into educational, preventive and therapeutic oral health services.

Health Promotion and Disease Prevention

5. Health Education and Community Connection

- 5.1 Endorse health literacy and disease prevention.
- 5.2 Communicate and provide health education and oral self-care to diverse populations.
- 5.3 Facilitate learning platforms for communities of interest by providing health education through collaboration with dental and other professionals.
- 5.4 Promote the values of the dental profession through service-based activities.
- 5.5 Evaluate outcomes for future activities supporting health and wellness of individuals and communities.

6. Advocacy

- 6.1 Promote an ethical and equitable patient care and practice environment by demonstrating inclusion of diverse beliefs and values.
- 6.2 Uphold civic and social engagement through active involvement in professional affiliations to advance oral health.

Professional Development and Practice

7. Professional Growth

- 7.1 Commit to lifelong learning for professional and career opportunities in a variety of roles and settings.
- 7.2 Engage in research, education, industry involvement, technological and professional developments and/or advanced degrees.
- 7.3 Demonstrate self-awareness through reflective assessment for continued improvement.

8. Business Practices

- 8.1 Facilitate referrals to and consultations with relevant health care providers and other professionals to promote equitable and optimal patient care.
- 8.2 Promote economic growth and sustainability by meeting practice goals.
- 8.3 Create and maintain comprehensive, timely and accurate records.

8.4 Protect privacy, confidentiality and security of the patients and the practice by complying with legislation, practice standards, ethics and organizational policies.

9. Leadership

- 9.1 Develop and use effective strategies to facilitate change.
- 9.2 Inspire and network with others to nurture collegial affiliations.
- 9.3 Solicit and provide constructive feedback to promote professional growth of self.

Discipline-specific Competencies--Dental Hygiene

DH. 1 Essential Knowledge

DH. 1.1 Apply the knowledge of the following sciences during the dental hygiene process of care:

- Microbiology
- Human anatomy and physiology
- Human cellular biology
- Chemistry
- Biochemistry
- Immunology and pathology
- Nutrition
- Pharmacokinetics

DH. 1.2 Apply the knowledge of the following behavioral sciences during the dental hygiene process of care:

- Sociology
- Psychology
- Interpersonal communication

DH. 2 Person-centered Care

2.1 Assessment

- DH. 2.1.1 Accurately collect and document a comprehensive medical, dental, social health history and diagnostic data.
- DH. 2.1.2 Critically analyze all collected data.
- DH. 2.1.3 Identify predisposing, etiologic, environmental and social risk factors for person centered care.

2.2 Dental Hygiene Diagnosis

DH. 2.2.1 Analyze comprehensive medical, dental and social health history.

DH. 2.2.2 Integrate observational and diagnostic data as part of the dental hygiene diagnosis.

2.3 Planning

- DH. 2.3.1 Use the patient's assessment to establish an optimal and realistic, person-centered dental hygiene care plan through mutual communication.
- DH. 2.3.2 Use all aspects of the dental hygiene diagnosis in combination with the person's values, beliefs and preferences to develop a dental hygiene care plan through shared decision making.

2.4 Implementation

- DH. 2.4.1 Obtain informed consent based on the agreed-upon treatment plan.
- DH. 2.4.2 Execute individualized treatment based on the patient's dental hygiene diagnosis.
- DH. 2.4.3 Integrate educational, preventive and therapeutic services to provide comprehensive person-centered care.
- DH. 2.4.4 Use specialized skills and evidenced-based technology to promote dental and periodontal health.
- DH. 2.4.5 Continuously re-evaluate for modifications to achieve desired outcomes.

2.5 Evaluation and Documentation

- DH. 2.5.1 Evaluate the effectiveness of completed services.
- DH. 2.5.2 Analyze treatment outcomes of the dental hygiene process of care to determine improved health and modifications.
- DH. 2.5.3 Modify dental hygiene care plans as necessary to meet goals of patient and clinician.
- DH. 2.5.4 Identify necessary referrals for success of the treatment outcomes, including intraprofessional and interprofessional health care providers, supporting professions and patient advocates.
- DH. 2.5.5 Accurately document assessment findings and data, dental hygiene diagnosis and care plan, implementation, outcome evaluation and any communication between professionals and patient and anyone else in the circle of care.

Special requirements

Admission requirements include two years of liberal arts study with a minimum of 60 semester hours of transferable quality academic course credits. By completing these 60 semester hours, students will complete the general education requirements of the degree. More information concerning the admission requirements for VCU students is located in the undergraduate study section of this Bulletin that describes the pre-health major in dental hygiene (<https://bulletin.vcu.edu/undergraduate/college-humanities-sciences/prehealth-majors/dental-hygiene/>).

- **GPA** – A minimum GPA of 3.0 based on a 4.0 scale in the cumulative courses and a minimum GPA of 3.0 in math/sciences is required.
- **English proficiency** – To successfully complete the dental hygiene curriculum, students are required to communicate clearly (in English) with faculty, students, staff and patients. To assure such competence, the Dental Hygiene Program requires any applicant

whose native language is not English and who has been educated primarily outside of the United States to submit official Test of English as a Foreign Language or International English Language Testing System scores. Applicants are required to submit an official score with the application packet. The test must have been taken within the past two years. The Dental Hygiene Program does not conditionally admit applicants who have not met the requirement for proof of English proficiency.

You may be exempt from this requirement if:

- You have successfully completed 26 or more transferable semester credits at a two- or four-year postsecondary institution in the U.S. and have completed the full freshman English (non-ESL) requirement at that school with a minimum grade of C.
- or
- You have successfully completed 60 or more transferable semester credits at a two- or four-year postsecondary institution in the U.S.

No student will be considered for admission until proof of English proficiency is determined.

TOEFL: VCU's Dental Hygiene Program minimum TOEFL score requirements are 550 (paper), 213 (computer) or 80 (internet-based). For more information about TOEFL testing, go to www.ets.org (<http://www.ets.org>).

IELTS: VCU's Dental Hygiene Program minimum IELTS score requirement is 6.0.

Degree requirements for Dental Hygiene, Bachelor of Science (B.S.)

Course	Title	Hours
General education (https://bulletin.vcu.edu/undergraduate/undergraduate-study/general-education-curriculum/)		
Select 30 credits of general education courses in consultation with an adviser. ¹		
Major requirements		
• Major core requirements		
DENH 301	Dental Hygiene Theory I	5.5
DENH 302	Dental Hygiene Theory II	2
DENH 312	Community Oral Health Education and Promotion	2
DENH 327	Clinical Dental Hygiene I	4
DENH 342	Nutrition	3
DENH 347	Clinical Dental Hygiene Summer Clinic	2
DENH 401	Dental Hygiene Theory III	2
DENH 402	Dental Hygiene Theory IV	2
DENH 407	Evidence-Based Dental Hygiene Practice	2
DENH 411	Dental Public Health I	2
DENH 412	Dental Public Health II	2
DENH 422	Current Issues, the Law and Ethics	2
DENH 437	Clinical Dental Hygiene II	5
DENH 447	Clinical Dental Hygiene III	5
DENH 457	Clinical Service-learning	2
DHBS 301	Head and Neck Anatomy for Dental Hygienists	3

DHBS 302	Microscopic Anatomy	2
DHBS 341	Pharmacology and Pain Control for Dental Hygiene	4
DHBS 365	Infection and Immunity	2
GENP 302	Dental Materials	2
GENP 311	Oral Anatomy	2
IPEC 501	Foundations of Interprofessional Practice	1
ORPT 301	Dental Radiology	1.5
ORPT 324	Oral Pathology	3
ORSG 431	Management of the Medically Compromised Dental Patient and Medical Emergencies in the Dental Office	2
PERI 326	Periodontics I	1
PERI 329	Periodontics II	2

Ancillary requirements

Additional subjects and credits required for admission ¹	39
English (6-9 credits)	
General biology with laboratory (3-5 credits)	
College chemistry with laboratory (3-5 credits)	
Anatomy with laboratory (3-5 credits)	
Physiology with laboratory (3-5 credits)	
Microbiology with laboratory (3-5 credits)	
Humanities (3 credits)	
Introductory sociology (3 credits)	
Introductory psychology (3 credits)	
Speech (3 credits)	
Statistics (3 credits)	
Visual or performing arts (3 credits)	
Electives	

Total Hours 128

¹

Some course work completed toward admission will also fulfill general education requirements. Admission to the program requires 60 credits.

The minimum number of credit hours required for this degree is 128.

What follows is a sample plan that meets the prescribed requirements within a four-year course of study at VCU. Please contact your adviser before beginning course work toward a degree.

Credits required for admission to program: 60

Freshman year

Fall semester	Hours
Courses taken toward admission to program	15
Term Hours:	15

Spring semester

Courses taken toward admission to program	15
Term Hours:	15

Sophomore year

Fall semester

4 Dental Hygiene, Bachelor of Science (B.S.)

Courses taken toward admission to program	15
Term Hours:	15
Spring semester	
Courses taken toward admission to program	15
Term Hours:	15
Junior year	
Fall semester	
DENH 301 Dental Hygiene Theory I	5.5
DHBS 301 Head and Neck Anatomy for Dental Hygienists	3
DHBS 302 Microscopic Anatomy	2
DHBS 365 Infection and Immunity	2
GENP 311 Oral Anatomy	2
IPEC 501 Foundations of Interprofessional Practice	1
ORPT 301 Dental Radiology	1.5
PERI 326 Periodontics I	1
Term Hours:	18
Spring semester	
DENH 302 Dental Hygiene Theory II	2
DENH 327 Clinical Dental Hygiene I	4
DENH 342 Nutrition	3
DHBS 341 Pharmacology and Pain Control for Dental Hygiene	4
ORPT 324 Oral Pathology	3
PERI 329 Periodontics II	2
Term Hours:	18
Summer semester	
DENH 312 Community Oral Health Education and Promotion	2
DENH 347 Clinical Dental Hygiene Summer Clinic	2
GENP 302 Dental Materials	2
Term Hours:	6
Senior year	
Fall semester	
DENH 401 Dental Hygiene Theory III	2
DENH 407 Evidence-Based Dental Hygiene Practice	2
DENH 411 Dental Public Health I	2
DENH 437 Clinical Dental Hygiene II (capstone)	5
DENH 457 Clinical Service-learning ¹	
ORSG 431 Management of the Medically Compromised Dental Patient and Medical Emergencies in the Dental Office	2
Term Hours:	13
Spring semester	
DENH 402 Dental Hygiene Theory IV	2
DENH 412 Dental Public Health II	2
DENH 422 Current Issues, the Law and Ethics	2
DENH 447 Clinical Dental Hygiene III (capstone)	5
DENH 457 Clinical Service-learning ¹	2
Term Hours:	13
Total Hours:	128

¹ DENH 457 is a yearlong course with grade and credit assigned after completion of second semester.

The minimum number of credit hours required for this degree is 128.

ADVERTISEMENT

ADA News.



New ADA policies empower states to alleviate dental workforce shortage

ADA cites urgency, flexibility, commitment to high standards in response to American Dental Hygienists' Association

by Olivia Anderson

November 15, 2024

The ADA House of Delegates passed a series of [resolutions](#) that aim to address the dental workforce shortage, an issue ADA leaders say is among their top priorities. With an insufficient workforce, the ADA said, care cannot be delivered to patients.

Included are three resolutions that cover allowing internationally trained dentists a path to U.S. licensure; letting active dental students and residents practice hygiene if they've met certain competency requirements; and increasing the

number of faculty and students in allied dental education programs.

In a Nov. 7 letter to ADA President Brett Kessler, D.D.S., Erin Haley-Hitz, American Dental Hygienists' Association President and registered dental hygienist, expressed concern about the three resolutions' potential effect on patient safety, educational standards and professional integrity.

"Such changes fail to address oral-systemic health and the underlying issues that are driving many dental hygienists to leave the profession. The measures proposed in these resolutions — whether intended or not — threaten professional integrity and patient outcomes and fundamentally undermine the dental hygiene profession," Ms. Haley-Hitz wrote in the letter.

In a Nov. 14 [response](#) to Ms. Haley-Hitz, Dr. Kessler reassured her that the ADA remains committed to the highest standards of education and patient safety in dentistry.

"These resolutions were developed with a careful eye toward addressing the workforce shortages that are impacting patient access to care, while also maintaining licensure and practice standards," reads the letter. "In short, our goal is to find practical and responsible solutions to fill critical staffing gaps with qualified, well-trained individuals — without compromising on the standards that our patients deserve."

The letter goes on to state that the resolutions help address the workforce shortage by allowing dental professionals a voice in working towards better access to oral health care. Although the ADHA expressed concern specifically regarding resolutions 401H-2024, 513H-2024 and 514H-2024, the ADA said each one

upholds stringent licensure standards and ensures only qualified professionals practice in roles that match their training.

"The ADA also shares ADHA's commitment to enhancing workplace culture, professional development, and support for all members of the dental workforce. These resolutions are intended not only to help address the staffing shortage, but also to reduce the strain on current dental teams," wrote Dr. Kessler

ADA Health Policy Institute [survey data](#) tracks dental team recruitment challenges. In the third quarter of 2024, for instance, 33.9% of dentists indicated they were currently recruiting or had recruited a dental hygienist in the prior three months. Among those dentists, 91.7% indicated recruitment was very challenging or extremely challenging.

"We value and respect the essential role of dental hygienists in providing quality care, and we see these new policies as ways to complement — not replace — the vital role of hygienists on the dental team," the ADA letter reads.

Under 514H-2024, the ADA would encourage states to adopt policies allowing dentists who have completed a dental education program outside the U.S., subject to state licensing board requirements, to obtain a license to practice dental hygiene. Dr. Kessler reiterated in his letter that the ADA would not encourage states to adopt any policy allowing internationally trained dentists to work as dental hygienists unless that policy required applicants to pass board examinations demonstrating their competency.

The ADA said this new policy would allow it to give dentists a seat at the table on dental workforce issues, as some states already license internationally trained dentists as dental

hygienists and other states are considering similar legislative proposals.

Under 513H-2024, the ADA would encourage states to adopt policies allowing active dental students and residents who have completed all their required hygiene competencies to practice dental hygiene, or to practice as other dentist-supervised allied dental team members, subject to state licensure requirements. Dr. Kessler noted in his response that any policy under consideration would have to require dental students to meet state licensure requirements for hygiene before the ADA would encourage states to allow them to be licensed to practice hygiene.

Under 401H-2024, the ADA urges the Commission on Dental Accreditation to revise the accreditation standards for each of the allied dental education programs regarding faculty-student ratios to align with the accreditation standards for predoctoral dental education programs. Dr. Kessler said updating the standard would allow allied dental training programs more flexibility to increase class sizes, which are currently restricted due to the need to hire additional faculty.

Shane Ricci, D.D.S., chair of the ADA Council on Dental Practice, said he looks forward to addressing workforce challenges in the coming months.

“The Council on Dental Practice is eager to collaborate with other stakeholders to expedite priorities outlined in the ADA’s Strategic Forecast which include multifaceted opportunities to address workforce challenges,” he said.

Press Release

FOR IMMEDIATE RELEASE

ADHA Objects to ADA Non-Hygienist Staffing Resolutions, Calls for Constructive Collaboration

The American Dental Hygienists' Association calls for collaborative workforce solutions rather than compromising standards and patient safety through unlicensed practice.

CHICAGO, November 5, 2024 – In an open letter to the healthcare community released today, American Dental Hygienists' Association (ADHA®) President Erin Haley-Hitz, RDH issued a strong objection to recently passed American Dental Association (ADA) resolutions that would eliminate faculty-to-student ratios in dental hygiene programs and allow unlicensed practitioners to perform dental hygiene services.

"The proposed measures outlined in these resolutions threaten professional integrity and patient outcomes, and fundamentally undermine the dental hygiene profession," said Haley-Hitz. "ADHA strongly believes that rather than diminishing professional standards and undermining a complementary profession, constructive efforts should be directed toward improving workplace culture, enhancing professional development opportunities, and offering competitive benefits."

The full text of President Haley-Hitz's letter follows:

November 5, 2024

Dear Colleagues and Members of the Healthcare Community,

The American Dental Association (ADA) House of Delegates recently voted on and passed Resolutions 401, 413 and 514B, that aim to remove faculty-to-student ratios in dental hygiene programs and allow dental students and foreign trained dentists to practice dental hygiene in the United States, without passing a state licensing exam. We believe these resolutions pose significant risks to educational and professional standards and patient safety.

As the leading voice for dental hygienists in the U.S., the American Dental Hygienists' Association (ADHA®) leadership voiced opposition to these resolutions mid-October, in the form of testimony submitted to the relevant ADA House of Delegates Reference Committees and through an [open letter to the healthcare community](#), outlining our substantive objections and urging the House of Delegates to reject these proposals and focus on solutions that respect the distinct professional roles within dentistry and dental hygiene.

I sent a letter to the ADA on Friday, November 2, 2024, expressing ADHA's disappointment at the passage of these resolutions. The framework of these resolutions purportedly addresses workforce issues, but the resolutions effectively compromise educational quality, established standards, patient safety and appropriate pathways to practice.

Dental hygienists face substantial workplace challenges, such as reduced time for patient care, overburdened schedules, and emerging workforce models that potentially threaten to compromise educational and licensure standards. The proposed changes fail to address oral-systemic health nor the underlying issues that are driving many hygienists to leave the profession. The proposed measures outlined in these resolutions threaten professional integrity and patient outcomes, and fundamentally undermine the dental hygiene profession.

ADHA strongly believes that rather than diminishing professional standards and undermining a complementary profession, constructive efforts should be directed toward improving workplace culture, enhancing professional development opportunities, and offering competitive benefits. These measures can address dental hygiene recruitment and retention without compromising the integrity of the profession and can protect the public from potentially inadequate care by under-trained or unlicensed individuals.

Creating practice environments that foster professional autonomy and empower dental hygienists to fully embrace their role will not only lead to better health outcomes for the public but will also improve workforce issues. When dental hygienists have greater control over their environment and practice, they will have greater career contentment, sense of purpose and professional longevity.

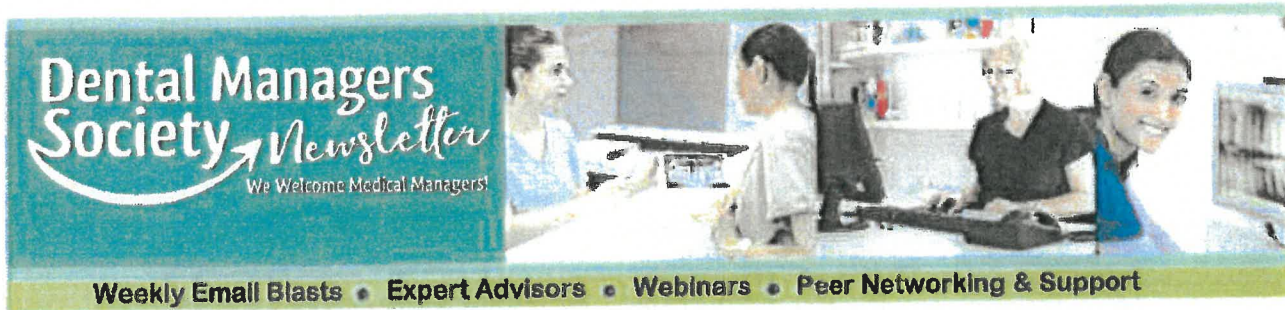
ADHA is currently addressing these objectives through active initiatives, and we have invited the ADA to meet and discuss partnering on these constructive efforts.

Sincerely,



Erin Haley-Hitz, RDH, BSDH, MS, FADHA, MAADH
ADHA President 2024-2025

membership@dentalmanagerssociety.com



Home

Team of Experts

Contact Us



Legislation

Allows Foreign

Trained

Home / Team of Experts / Legislation Allows Foreign Trained Dentists New Responsibil

Dentists New

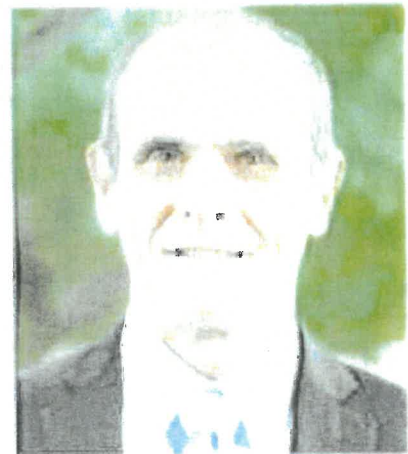
Responsibilities

< Previous Next >

Legislation Allows Foreign Trained Dentists New Responsibilities

On January 10, 2025, new legislation in Massachusetts was passed and signed into law allowing foreign trained dentists with at least five years of experience and certification from an approved jurisdiction to obtain a dental hygiene license.

“An Act Relative to Dental Hygienist Reciprocal Licensure,” sponsored by Representative Tackey Chan (Quincy) also allows full-time dental students who have completed at



least four semesters of dental school to practice as dental hygienists in Massachusetts. The law came as a resulting of efforts by Massachusetts dentist Dr. Abe Abdul and Representative Chan to respond to a need for more hygienists in the state as well as to tap into the best use of qualifications of dental providers coming from other countries with appropriate dental training programs as well as the dental students with comparable training at the end of four semesters of full dental licensure education at an accredited dental school.

Many foreign trained dentists in Massachusetts have limited licenses which allow them to serve as dental school instructors, but need to have graduated from an accredited dental school in the United States or another approved jurisdiction such as Canada to gain full licensure as dentists.

Dr. Abdul, who has gained a reputation for being a driving force behind significant dental legislation such as the dental loss ratio law requiring minimum patient care expenditures from dental insurers (which now continues to gain momentum with similar legislation in other states), acknowledged the participation of the Massachusetts Dental Hygienists Association, which wanted additional verblage added to the bill to ensure patient safety.

The law also mandates that the jurisdiction where the dentist received his or her training and education requires a degree of competency determined by the Board of Registration in Dentistry to comparable to that required of hygienist examinees in Massachusetts. The pool of approximately 5000 foreign trained dentists who seek admission to the 200 annually available openings in dental

Contact Info:

Brian Hatch

Hatch Legal Group

8 North Main Street, Suite

403

Attleboro, MA 02703

HatchLegalGroup.com

brianhatch@hatchlawoffices.co

508-222-6400

schools in Massachusetts provides significant skilled potential hygienists who may qualify for the new category

Interestingly the newly passed Massachusetts legislation has already attracted formal attention from other state legislatures, just as the dental loss ratio law did. In Virginia, to alleviate a shortage of dental providers there, a comparable bill allowing foreign trained dentists to practice as hygienists has been introduced by the only dentist in the Virginia legislature, Senator Todd Pillion (R-Washington County). Virginia also has a law similar to the existing law in Massachusetts making foreign trained dentists eligible to serve as dental school instructors. That law had sunset provision expiring on July, 2025, and two new bills filed in December will extend that law.

Share This Story, Choose Your Platform!



SOCIAL

Search...





COMMONWEALTH of VIRGINIA

Arne W. Owens
Director

Department of Health Professions
Perimeter Center
9960 Mayland Drive, Suite 300
Henrico, Virginia 23233-1463

www.dhp.virginia.gov
PHONE (804) 367- 4400

TO: The Honorable Robert D. Orrock
Chairman, House Committee on Health, Welfare, and Institutions

The Honorable Louise L. Lucas
Chairman, Senate Committee on Education and Health

FROM: Arne W. Owens
Director, Virginia Department of Health Professions

DATE: October 2, 2023 *Arne W. Owens*

RE: Report Regarding Licensure of Dentists and Dental Hygienists in the
Commonwealth pursuant to Ch. 485 of the 2023 General Assembly

This report is submitted by the Department of Health Professions in compliance with Chapter 485 of the 2023 Acts of Assembly, which states:

The Virginia Department of Health Professions shall convene a work group consisting of representatives of the Virginia Dental Association, the Virginia Dental Hygienists' Association, the Association of Dental Support Organizations, the Virginia Board of Dentistry, and other relevant stakeholders to analyze licensure requirements for dentists and dental hygienists in the Commonwealth and determine what changes to such requirements may be warranted, if any, to ensure access to affordable, quality dental care throughout the Commonwealth. The work group shall (i) compare licensure requirements for dentists and dental hygienists in the Commonwealth with such requirements in other states and the District of Columbia; (ii) analyze the number of licensed dentists in the Commonwealth relative to population growth and geography; (iii) identify the risks and benefits to the public if a licensure by endorsement pathway were to exist in the Commonwealth; and (iv) identify any other licensure pathways that would serve the public good. The work group shall report its findings along with any recommendations for legislation to the

House Committee on Health, Welfare and Institutions and the
Senate Committee on Education and Health by October 1, 2023.

Should you have questions about this report, please feel free to contact me at (804) 367-4648 or arne.owens@dhp.virginia.gov.

AO/EB
Enclosure

CC: The Honorable John Littel, Secretary of Health and Human Resources

Preface

This report is submitted in compliance with Chapter 485 of the 2023 Acts of Assembly:

The Virginia Department of Health Professions shall convene a work group consisting of representatives of the Virginia Dental Association, the Virginia Dental Hygienists' Association, the Association of Dental Support Organizations, the Virginia Board of Dentistry, and other relevant stakeholders to analyze licensure requirements for dentists and dental hygienists in the Commonwealth and determine what changes to such requirements may be warranted, if any, to ensure access to affordable, quality dental care throughout the Commonwealth. The work group shall (i) compare licensure requirements for dentists and dental hygienists in the Commonwealth with such requirements in other states and the District of Columbia; (ii) analyze the number of licensed dentists in the Commonwealth relative to population growth and geography; (iii) identify the risks and benefits to the public if a licensure by endorsement pathway were to exist in the Commonwealth; and (iv) identify any other licensure pathways that would serve the public good. The work group shall report its findings along with any recommendations for legislation to the House Committee on Health, Welfare and Institutions and the Senate Committee on Education and Health by October 1, 2023.

Contents

I. Executive Summary.....	1
II. Comparison of licensure requirements	2
III. Dentists and dental hygienists relative to population	4
IV. Licensure by endorsement pathway.....	4
V. Other licensure pathways.....	5
VI. Additional considerations	5

I. Executive Summary

Pursuant to House Bill 2251, passed during the 2023 General Assembly Session, the Board of Dentistry convened a workgroup on July 21, 2023 to:

1. compare licensure requirements for dentists and dental hygienists in the Commonwealth with such requirements in other states and the District of Columbia;
2. analyze the number of licensed dentists in the Commonwealth relative to population growth and geography;
3. identify the risks and benefits to the public if a licensure by endorsement pathway were to exist in the Commonwealth; and
4. identify any other licensure pathways that would serve the public good.

The workgroup found that the licensure requirements for dentists and dental hygienists were generally comparable with the majority of United States jurisdictions. The workgroup additionally found that numbers of dentists and dental hygienists have remained stable in terms of available workforce and the number of licensees planning to retire in the next 10 years.

The workgroup noted that licensure by endorsement is currently available in Virginia for dentists and dental hygienists. Such a pathway has been available for many years and is successfully used by applicants.

Finally, the workgroup examined other licensure pathways. The workgroup considered the possibility of joining a dental compact. Evidence examined during the workgroup and confirmed following the workgroup show that the currently available dental compact may allow licensure of individuals who do not meet the educational requirements for Virginia. The workgroup also discussed potential pathways for licensure for foreign graduates used by another jurisdiction which required supervised clinical practice in the state prior to licensure.

The workgroup did not suggest or recommend changes to the current licensure process, the endorsement process, or any specific pathway to licensure not currently in use in Virginia based on the information reviewed by the workgroup.

Workgroup Members

Margaret F. Lemaster
R.D.H., Board Member

William C. Bigelow, D.D.S.
Board Member

Lisa Ward
Vice President, Communications
Association of Dental Support Organization (ADSO)

Heather Tuthill
President
Virginia Dental Hygienists' Association (VDHA)

Benjamin H. Traynham, Esq.
Representative
Virginia Dental Association (VDA)

Jamie C. Sacksteder
Executive Director
Virginia Board of Dentistry

Erin L. Barrett
Director of Legislative and Regulatory Affairs
Department of Health Professions

II. Comparison of licensure requirements

Licensure by examination and licensure by endorsement pathways currently in existence in Virginia were reviewed by the workgroup.¹ The workgroup made no suggestions for change in Virginia's current licensure by examination or endorsement processes.

A. Licensure by examination

Licensure by examination is a licensure pathway used most often by new graduates. It may be used by experienced dentists and dental hygienists from other jurisdictions who do not meet requirements for licensure by endorsement. Virginia's requirements for licensure by examination are similar to other jurisdictions in the United States.

1. *Dentists*

For licensure by examination, Virginia requires graduation from a program accredited by the Commission on Dental Accreditation ("CODA") or the Commission on Dental Accreditation of Canada ("CDAC") (*see* 18VAC60-21-200), which is the same requirement as 36 other states in the U.S. Virginia allows foreign-trained applicants to receive licenses in Virginia if the applicant completes a 12-month post-doctoral advanced general dentistry program or a post-doctoral dental program of at least 24 months in any other specialty that includes a clinical component. *See* 18VAC60-21-200. Virginia requires passage of the American Board of Dental Examiners ("ADEX") exam as the required clinical competency exam for licensure. *See* Va. Code § 54.1-2709(B)(iv). 48 states accept the ADEX examination for licensure; 15 states require passage of the ADEX examination. The fee of \$400 for licensure by examination is lower than 17 states.

¹ For information reviewed by the workgroup regarding license requirements in Virginia, including national comparisons, see: https://townhall.virginia.gov/L/GetFile.cfm?File=Meeting\21\35453\Agenda_DHP_35453_v2.pdf. Pages 2 – 20 provide information related to licensure of dentists, and pages 21 – 35 provide information related to licensure of dental hygienists.

Virginia does not require a background check or a jurisprudence exam. 25 states require a criminal background check prior to licensure, and 41 states require passage of a jurisprudence exam.

2. *Dental hygienists*

Virginia requires graduation from a CODA or CDAC accredited program for licensure as a dental hygienist, which is the same requirement as 37 other states in the U.S. Virginia requires passage of the ADEX examination for licensure. 48 states accept the ADEX examination for licensure; 14 states require passage of the ADEX examination. The fee of \$175 for licensure by examination is lower than 18 other states.

Virginia does not require criminal background checks for licensure as a dental hygienist. 23 states currently require a criminal background check for licensure. Virginia does not accept foreign-trained applicants for licensure as a dental hygienist. Nationally, only 12 states accept foreign-trained applicants. All such states impose additional requirements on applicants, and several states provide only a restricted license.

B. Licensure by endorsement

Both dentists and dental hygienists may be licensed by endorsement in Virginia. Regulations related to licensure by endorsement refer to this pathway as “licensure by credentials,” consistent with terminology used across the United States related to dentistry. *See* 18VAC60-21-210(B) (setting forth requirements for licensure by credentials for dentists); *see also* 18VAC60-25-150 (setting forth requirements for licensure by credentials for dental hygienists).²

1. *Dentists*

Virginia’s licensing fee for licensure by endorsement is lower than 23 other states. Virginia’s educational requirements are identical to 36 other states. Virginia’s active practice requirement is the same as 27 other states.³ 42 states require an applicant take and pass a jurisprudence exam. The fee of \$500 for licensure by endorsement is lower than 23 states.

2. *Dental hygienists*

Virginia’s educational requirements are identical to 37 other states. Virginia’s active practice requirement is lower than 27 states.⁴ The fee for licensure by endorsement as a dental hygienist of \$275 is lower than 15 other states.

² To avoid confusion and for consistency with the language of HB2251, this pathway will be referred to as “licensure by endorsement” within this report.

³ Virginia requires active practice for five out of the last six years immediately preceding application for licensure by endorsement to practice dentistry.

⁴ Virginia requires active practice for 24 out of the last 48 months immediately preceding application for licensure by endorsement to practice dental hygiene.

III. Dentists and dental hygienists relative to population

Data produced by the Department of Health Professions' Health Workforce Data Center ("HWDC") provided the following information related to licensed dentists and licensed dental hygienists relative to population.⁵

A. Licensed dentists

Currently, there are 66.19 dentists per 100,000 people in the Commonwealth of Virginia, which is higher than the density nationally of 60.84 dentists per 100,000 people in the United States. The highest overall concentration of dentists is reported in the Northern Virginia area, with Central Virginia and Hampton Roads having the next highest concentrations. The highest number of dentists per 100,000 residents is reported in Northern Virginia, with the Eastern Virginia Region in second place.

Dentists have seen consistent increases in workforce from 2013 – 2021, with the profession adding 9% more licensees during that time. In 2022, a 2% drop in licensed dentists was recorded by the HWDC, although the overall number of licensed dentists remains stable. The median age of dentists is 48 years old, a number that has been relatively stable and has decreased from a high of 50 in 2015. The number of dentists planning to retire in 10 years has remained stable at 28%, which is substantially similar to all yearly results since 2013.

B. Licensed dental hygienists

Currently, there are 61.21 dental hygienists per 100,000 people in the Commonwealth of Virginia, which is lower than the density nationally of 65.04 dental hygienists per 100,000 people in the United States. The highest overall concentration of dental hygienists is reported in the Northern Virginia area, with Hampton Roads reporting the second highest concentration. The highest number of dental hygienists per 100,000 residents is reported in Hampton Roads, with the West Central Region in second place.

Dental hygienists have seen consistent increases in workforce from 2013 – 2022, with a total of 18% more licensees added during that time. The median age of dental hygienists is 43 years old, a number that has been relatively stable. The number of dental hygienists planning to retire in 10 years has remained stable at 27%, although the overall percentage of dental hygienists planning to retire in 10 years has increased from the 23% reported in 2013.

IV. Licensure by endorsement pathway

As stated under Part II, a licensure by endorsement pathway exists for both dentists and dental hygienists. *See* 18VAC60-21-210(B) (setting forth requirements for licensure by credentials for dentists); *see also* 18VAC60-25-150 (setting forth requirements for licensure by credentials for dental hygienists). HB2251 directed the workgroup to "identify the risks and benefits to the public

⁵ See Virginia Oral Health Workforce: Digging Deeper, Yetty Shobo, Ph.D, July 12, 2023 presentation, available at: https://www.dhp.virginia.gov/media/dhpweb/docs/hwdc/presentations/BOD_072223.pdf.

if a licensure by endorsement pathway were to exist in the Commonwealth.” Because this pathway already exists, the workgroup did not make findings regarding this portion of the legislation.

V. Other licensure pathways

The workgroup considered the Dental Licensure Compact as created by the Council of State Governments.⁶ The Board of Dentistry has previously considered the Compact and declined to support it for a variety of reasons, including that the licensure requirements for the Compact do not meet the licensure requirements for Virginia.⁷ The ability of the Compact to impose as-yet undetermined fees on member states and the cost of implementing the required criminal background check requirement on applicants creates an unknown cost to the Commonwealth that may not be justified given the current low participation in the Compact.⁸

The workgroup briefly discussed requirements for foreign dental applicants in Minnesota. That jurisdiction allows foreign applicants, following passage of the Test of English as a Foreign Language (“TOEFL”) examination and submission of educational equivalency through the Foreign Credential Service of America, to obtain a limited general license. The applicant must then work under the supervision of a licensed dentist for two years before applying to the Minnesota Board of Dentistry for an unrestricted license to practice dentistry. Using this model in Virginia would require Code revision and regulatory changes.

VI. Additional considerations

The workgroup received the following information from Board of Dentistry staff regarding applications to practice in Virginia.

The Board removed unnecessary barriers to the licensure application process and streamlined staff review over the last year. Thus, even though applications for the same six-month period in 2022⁹ and 2023¹⁰ increased by 206 applications, Board staff processed 217¹¹ more applications during that time, which more than made up for the increase. Streamlining efforts included: removal of unnecessary forms and information included in applications; receiving

⁶ Currently, only three states have enacted legislation to join the Compact. See ddhcompact.org/compact-map/.

⁷ Although Virginia and a large number of states require graduation from a CODA or CDAC accredited program, the Compact (1) does not include CDAC, which may exclude Canadian applicants, and (2) contains language which may allow for non-CODA accredited education to satisfy licensure requirements, should the Department of Education approve additional accrediting bodies in the future.

⁸ Following the workgroup, another dental compact was proposed through the American Association of Dental Boards (soon to become the Federation of State Dental Boards). This new compact will be modeled on the Interstate Medical Licensure Compact (“IMLC”), and similar to the IMLC will require individual applicants to apply for “compact” licenses in member states. Compact costs will predominantly be borne by applicants, but Virginia would incur a fiscal impact in the implementation of criminal background checks. Because this compact was proposed after the workgroup met, it was not considered by the workgroup. As of August 30, 2023, no public draft compact was available to provide as a citation.

⁹ From January 1, 2022 – July 1, 2022, the Board received 398 applications.

¹⁰ From January 1, 2023 – July 1, 2023, the Board received 604 applications.

¹¹ From January 1, 2022 – July 1, 2022, the Board processed 371 applications. From January 1, 2023 – July 1, 2023, the Board processed 588 applications.

information electronically; and not requiring original documentation when information can be verified another way.

Internationally Trained Dentist

- **State Requirements for Internationally Trained Dentist to become DH**
- **Topic Question for Internationally Trained Dentist to become DH**

<u>State</u>	<u>Experience Requirements</u>	<u>Degree Requirements</u>	<u>Exam Requirements</u>	<u>Other Requirements</u>
Florida	None	Credentials will be evaluated by World Educational Services or ECE to ensure education is equivalent of a US dental hygiene program	Pass the NBDHE, ADEX, and Jurisprudence	Proof of CPR Certification
Massachusetts	5 years	regulations/ application have not been created yet. Law just passed January 2025. .	regulations/ application have not been created yet. Law just passed January 2025.	Training and Education requires a degree of competency determined by the Board.



Virginia Department of
Health Professions
Board of Dentistry

Topic Questions for Internationally Trained Dentist to work as Dental Hygienists

1. What are the perceived dangers of an internationally trained dentist working as a dental hygienist?
 - a. Are they the same dangers if they pass national exams and/or regional clinical exams?
2. Do educational standards vary significantly across countries and internationally trained dentists?
 - a. Do you feel that the same dangers would be there if an internationally trained dentist enrolled in a CODA accredited program and received advanced standing or transfer of credit for some of their international education?
3. What do you feel are patient safety concerns, if any?
 - a. What do you feel needs to be in place to address those patient safety concerns?
4. What are the other concerns of internationally trained dentist working as a dental hygienist?
 - a. Do you feel like it undermines the dental hygiene profession? Why or why not?
 - b. Do you feel there is a lack of clinical experience? Why? How do you know?
 - c. Do you feel there are ethical concerns? Why? What are they?
5. Is there a way Virginia can establish a pathway and competence of an internationally trained dentist to practice as a dental hygienist? Pathways to consider:
 - a. Passing the national examination (NBDHE) and/or regional clinical examination (ADEX)
 - b. Passing the TOEFL (Test of English as a Foreign Language) or ELTS (English Language Testing Systems) to prove comprehension of the English Language
 - c. Completing a CODA accredited program as an advance standing with an evaluation of international education by the CODA program or the evaluation of credentials to ensure education is equivalent (World Education Services, Educational Credential Evaluators, or National Association of Credential Evaluation Services)
 - d. Proof of CPR
 - e. Proof of Infection Control Training
 - f. Amount of experience as a practicing dentist



Virginia Department of
Health Professions
Board of Dentistry

6. Do you feel there are other concerns that have not been raised or addressed in regard to internationally trained dentist working as dental hygienists? What are they?