MARYLAND STATE BOARD OF DENTAL EXAMINERS

Report Form for Practice Under General Supervision

NEW ☐ or RENEWAL ☐

Date of Completion: _____

New Facility: _____

Address: _____

City: _____ State: _____ Zipcode: _____

Authorized Contact Name and Title: _____

Type of Facility:

_____ State Government _____ Federal Government

_____ Local Government _____ Public Health Department

Name of agency that owns or operates facility: _____

Location of facility and all other sites where Dental Hygiene services will be provided (attach list if more than one)": _____

_____

Name(s) of Supervising Dentist(s) affiliated with facility who will be responsible for carrying out the requirements necessary for the facility to operate under general supervision. Please include license number(s) of each dentist. (List may be attached)

Name:_____ License #:_____

Name:_____ License #:_____

Name(s) of Dental Hygienist(s) who will provide dental hygiene services under general supervision. Please include license number(s) of each dental hygienist. (List may be attached)

Name:_____ License #:_____

Name:_____ License #:_____

I have reviewed and confirm that all of the dentists and hygienists listed in this report hold a current certificate evidencing Health Provider level C proficiency, or its equivalent, in cardiopulmonary resuscitation.

Name of person completing form: _____

Signature: _____ Date: _____

Please Note: This report expires and is to be completed every five years. An addendum report must be completed when new locations, new Dentists and new Dental Hygienists are added or changed within the agency.