

Dental Hygiene Advanced Procedure Therapeutic Use of Lasers Application

PLEASE PRINT CLEARLY WITH BLUE OR BLACK INK **\$10 check or money order- NO CASH**

Dental Hygienist Name _____ OK RDH # _____

Current Public Address _____

City _____ State _____ Zip _____

Daytime Phone Number _____ Email Address _____

Please refer to the rules 195:15-1-6.1 to verify that you qualify for the Advanced Procedure you are requesting. Was the course you took pre-approved by the Board?

(1) Therapeutic Use of Lasers

(a) A hygienist may apply for an Advanced Procedure permit for the therapeutic use of lasers under the direct/indirect supervision of a dentist.

(b) Definition: A hygienist with an advanced procedure permit to use a laser may be used, but limited to soft tissue decontamination, sulcular bacterial reduction, tissue disinfection.

(c) Requirements:

1. The hygienist must successfully complete an educational program as approved by the Board on laser use that is a minimum of 8 hours and includes both didactic and live, in-person clinical simulation training;
2. A certificate of successful course completion from the dental laser training entity shall be submitted to the Board of Dentistry.
 - (i.) A hygienist may use the laser within the scope of hygiene practice;
 - (ii.) A laser may not be used for the intentional cutting of hard or soft tissue;
 - (iii.) All lasers must be used in accordance with accepted safety guidelines and approved by the United States Federal Drug Administration for use in dentistry.
 - (iv.) When utilizing a laser pursuant to this Rule, at a minimum, the type of laser, settings used and details of procedures performed, must be documented in the patient's record.

- **Proof of an 8 hour or more course**_____
- **Copy of Course outline if course has not already been approved by the Board**_____
- **Affidavit by supervising dentist stating hygienist has been using laser for over 2 years** _____

AFFIDAVIT OF DENTIST

I, _____ do hereby attest that _____, the
(Dentist Name) (RDH Name and License Number)
listed Registered Dental Hygienist has been competently using a laser two or more years within my dental office. All information or statements made on this form(s) or any information given in connection therewith, to be true and correct. I understand and agree that this is a State of Oklahoma official document and any misrepresentation or fraudulent statement on any part of this form(s) may be grounds for disciplinary action as set forth by the Oklahoma State Dental Act 59 O.S. §Section 328.32.(A)(2), as well as other laws under the State of Oklahoma.

Dentist Name and License Number Printed Clearly Dentist Signature Date

Dental Hygienist Signature

IMPORTANT: Please be aware that the Committee requires the above documentation and if you do not submit the above documentation, there is no guarantee the Committee will be able to make a recommendation to the Board. Your request will be reviewed at the next regularly scheduled Committee meeting, which are typically 2-3 weeks prior to the Board Meetings. You will be notified in writing once the committee has made a recommendation and the Board approves such recommendation.

FOR COMMITTEE USE ONLY:

Date Reviewed: _____ Date Notified: _____

Recommendation: _____

Oklahoma Board of Dentistry

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