



QUARTERLY REPORT OF COMPLIANCE

Failure to provide all or any part of the requested information will result in the form being rejected as incomplete

Business and Professions Code section 1949 authorizes the Dental Hygiene Committee to impose various terms and conditions on licensees placed on probation. Every probationer is required to submit a quarterly declaration stating whether or not there has been compliance with all the conditions of probation. The declaration stating on forms provided and approved by the Committee. Is it the responsibility of each probationer to submit the forms each quarter. Failure to do so constitutes a violation of probation.

FOR BDE USE ONLY	
DATE RECEIVED _____	PORCESSED BY _____
<input type="checkbox"/> COMPLETE <input type="checkbox"/> INCOMPLETE	DATE RETURNED _____
REVIEWED BY _____	DATE _____
INTERVIEW DATE _____	<input type="checkbox"/> IN PERSON <input type="checkbox"/> TELEPHONE
STATUS <input type="checkbox"/> IN COMPLIANCE <input type="checkbox"/> NOT IN COMPLIANCE	
COMMENTS _____	
CASE NUMBER _____	
DATE MAILED TO SACRAMENTO _____	
<input type="checkbox"/> 1QTR <input type="checkbox"/> 2QTR <input type="checkbox"/> 3QTR <input type="checkbox"/> 4QTR <input type="checkbox"/> 5QTR YEAR _____	

SECTION A

(PLEASE PRINT OF TYPE)

PLEASE PUT AN ASTRISK * NEXT TO THE ADDRESS YOU WANT TO USE AS YOUR MAILING ADDRESS

NAME	LAST	FIRST	MIDDLE		
LICENCE NO: [] RDH <input type="checkbox"/> RDHAP <input type="checkbox"/> RDHEF <input type="checkbox"/> EXPERATION DATE					
RESIDENCE ADDRESS: NUMBER		STREET	CITY	STATE	ZIP CODE
PHONE #				<input type="checkbox"/> THIS IS A NEW ADDRESS	
OFFICE ADDRESS	NUMBER	STREET	CITY	STATE	ZIP CODE
PHONE #				<input type="checkbox"/> THIS IS A NEW ADDRESS	
DAYS OF PRACTICE				HOURS	
ADDITIONAL OFFICE ADDRESS	NUMBER	STREET	CITY	STATE	ZIP CODE
PHONE #				<input type="checkbox"/> THIS IS A NEW ADDRESS	
DAYS OF PRACTICE				HOURS	
NAME OF EMPLOYER, PARTNER, OR ASSOCIATE (if any, and as may be appropriate)					
LAST		FIRST	MIDDLE		
ADDRESS					
NAME OF YOUR PROBATION MONITOR:					

1. Are you actively practicing in the state of California? YES NO

If you answered NO, please indicate your last day of practice _____

2. During the reporting quarter have you resided or practiced outside the State of California YES NO

If you answered YES, please list the dates: _____

REQUIRED CONDITIONS OF PROBATION

SECTION B

1. Please provide full and complete information for each item that corresponds to your conditions of probation on your Quarterly Report of Compliance. Please indicate on each Quarterly Report of Compliance which items have been completed and what steps were taken to complete that item. In the event that you have not satisfied any parts of an item, please indicate what parts of the item have been completed. Use the space provided to FULLY describe ALL details. Attach separate sheets of paper if necessary to provide full details.
2. All Quarterly Reports of Compliance forms must be submitted within the first week of the month designated by your probation monitor. If you anticipate a delay of unable to submit your report, you must immediately contact your probation monitor.

SECTION C (Check Yes, No or Complete Box as Required)

If you answer YES, please provide the requested information.

If you answer NO; proceed to the next item.

If you answer COMPLETE, please provide the requested information and submit proof of completion. If this has been previously done, please proceed to the next item.

1. **SUSPENSION** YES NO COMPLETE

Dates suspension served: _____ FROM _____ TO _____

2. **REMEDIAL/ CONTINUING EDUCATION**

YES NO COMPLETE

Please list ALL remedial education course(s) that you have proposed or completed during the respective quarter. You must also submit documents which verify ALL the remedial education course(s) that you completed during the quarter. Remedial Education proposals must be submitted, on a Board form, before your indicated proposal due date and at least 30 days prior to the course date.

REQUIRED AREA(S)	HOURS REQUIRED	TO BE COMPLETED BY

COURSE NAME/ LOCATION	PROPOSAL SUBMITTED	BOARD APPROVED	DATE OF COURSE	HOURS	COMPLETED
	<input type="checkbox"/>	<input type="checkbox"/>			
	<input type="checkbox"/>	<input type="checkbox"/>			
	<input type="checkbox"/>	<input type="checkbox"/>			
	<input type="checkbox"/>	<input type="checkbox"/>			
	<input type="checkbox"/>	<input type="checkbox"/>			

COMMENTS _____

*PLEASE ATTACH A COPY OF CERTIFICATE OF COMPLETION

3. COURSE IN ETHICS

YES NO COMPLETE

Please list ALL ethics course(s) that you have proposed or completed during the respective quarter. You must also provide all documents which verify the ethics course(s) that you completed during the quarter. Ethics course(s) proposals must be submitted, on Board from, before your indicated proposal due date and at least 30 days prior to the course date.

HOURS REQUIRED		TO BE COMPLETED BY			
COURSE NAME/ LOCATION	PROPOSAL SUBMITTED	BOARD APPROVED	DATE OF COURSE	HOURS	COMPLETED
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>
COMMENTS					

*PLEASE ATTACH A COPY OF CERTIFICATE OF COMPLETION

4. COMMUNITY SERVICE

YES NO COMPLETE

Please list ALL community service hours that you have completed during the respective quarter. You must also submit a letter from the Board approved organization which lists the dates and hours of community service completed during the quarter. Community Service proposals must be submitted, on a Board form, before you indicated proposal due date.

Dental Related or Non-Dental related

HOURS REQUIRED PER YEAR	FOR HOW MANY YEARS	TOTAL HOURS COMPLETED THIS QUARTER	ORGANIZATION NAME/LOCATION /CONTACT PERSON	PROPOSAL SUBMITTED	BOARD APPROVED	TOTAL HOURS COMPLETED SINCE INCEPTION
_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____

* PLEASE ATTACH A LETTER FROM THE COMMUNITY SERVICE ORGANIZATION

5. PSYCHOLOGICAL EVALUATION

YES NO COMPLETE

NAME OF DOCTOR DOING EVALUATION EVALUATION DATE

WAS PSYCHOTHERAPY RECOMMENDED YES NO

6. PSYCHOTHERAPY

YES NO COMPLETE

NAME OF DOCTOR BOARD APPROVED YES PENDING

ADDRESS _____

FREQUENCY OF PSYCHOTHERAPY SESSIONS _____

HAS THE DOCTOR SUBMITTED QUARTERLY REPORTS YES NO

7. COST RECOVERY TO COMMITTEE

YES NO COMPLETE

AMOUNT TO BE PAID _____ TOTAL PAID THIS QUARTER _____ BALANCE DUE _____
TOTAL PAYMENT TO BE PAID BY _____ HAS AN ALTERNATE PLAN BEEN SUBMITTED YES NO
HAS PAYMENT PLAN BEEN APPROVED BY THE COMMITTEE YES NO
WHAT IS THE PAYMENT PLAN _____

8. RESTITUTION

YES NO COMPLETE

AMOUNT TO BE PAID _____ TOTAL PAID THIS QUARTER _____ BALANCE DUE _____
TOTAL PAYMENT TO BE PAID BY _____
PLEASE IDENTIFY WHO RESTITUTION IS BEING PAID TO _____
WHAT IS THE PAYMENT PLAN _____

9. DIVERSION EVALUATION COMMITTEE/PROGRAM

YES NO COMPLETE

HAVE YOU MAINTAINED COMPLIANCE WITH THE DIVERSION EVALUATION COMMITTEE? YES NO
WHAT IS THE STATUS OF YOUR PROGRESS IN THE DIVERSION PROGRAM? EXPLAIN.

10. ABSTINENCE FROM DRUGS/ ALCOHOL

YES NO

DESCRIBE YOUR CONTINUED PROGRESS IN ABSTAINING FROM ALCOHOL AND OTHER DRUGS: _____

11. BIOLOGICAL FLUID TESTING

YES NO

CHECK HERE IF YOU WERE TESTED THIS QUARTER.

12. EXAMINATION

YES

NO

COMPLETE

SUBJECT _____

DATE TAKEN TO BE TAKEN BY _____

DATE OF EXAM _____

COMMENTS: _____

13. SUPERVISED ENVIRONMENT

YES

NO

COMPLETE

DIRECT SUPERVISION

INDIRECT SUPERVISION

LENGTH OF SUPERVISION _____

HAS THE BOARD APPROVED A PLAN OF SUPERVISION YES NO

NAME OF SUPERVISOR OF MONITOR _____

ALTERNATE _____

COMMENTS _____

HAS A QUARTERLY REPORT BEEN SUBMITTED BY YOUR MONITOR? YES NO ATTACHED

14. RESTRICTED PRACTICE

YES

NO

COMPLETE

SPECIFIC RESTRICTIONS _____

IS YOUR ENTIRE STAFF AWARE OF YOUR RESTRICTION YES NO

DESCRIBE YOUR PROGRESS IN MAINTAINING YOUR RESTRICTED PRACTICE _____

15. OTHERS

ADDITIONAL INFORMATION (PLEASE IDENTIFY ITEM NUMBER AND ATTACH ADDITIONAL 8 1/2 X 11 PAGES, IF NECESSARY):

SECTION D

From the date of the Decision of Dental Hygiene Committee of California, placing me on probation to and including the date of this declaration, I **HAVE** been arrested or charged with a violation, or have been convicted of any violation of any Federal or State statute, or Country or City ordinance. (If answer is affirmative, use extra page for explanation.)

YES NO

From the date of Decision of Dental Hygiene Committee of California, placing me on probation to and including the date of this declaration, I **HAVE** complied with all of the rules and regulations of the Dental Hygiene Committee of California.

YES NO

From the date of the Decision of the Dental Hygiene Committee of California, placing me on probation to and including the date of this declaration, I **HAVE**, to the best of my knowledge, complied with each and every condition and term of probation granted to me by the Dental Hygiene of California.

YES NO

I hereby submit the Quarterly Report as required by the California Department of Consumer Affairs, Dental Hygiene Committee and its Order or probation thereof, and declare **UNDER THE PENALTY OF PERJURY** the laws of the State of California that I have read the foregoing report in its entirety and know its contents and that all statements made are true in every respect, and understand that misstatements or omissions of material fact may be cause for revocation of probation.

_____ Date _____

REMARKS (see attachment)

(Rev. 01/2010)