



## REGISTRATION OF SPONSORING ENTITY UNDER BUSINESS & PROFESSIONS CODE SECTION 901

In accordance with California Business and Professions Code Section 901(d), a non-government organization administering an event to provide health care services to uninsured and underinsured individuals at no cost may include participation by certain health care practitioners licensed outside of California if the organization registers with the California licensing authorities having jurisdiction over those professions. This form shall be completed and submitted by the sponsoring organization **at least 90 calendar days prior to the sponsored event.** *Note that the information required by Business and Professions Code Section 901(d) must also be provided to the county health department having jurisdiction in each county in which the sponsored event will take place.* Only one form (per event) should be completed and submitted.

### PART 1 – ORGANIZATIONAL INFORMATION

1. Organization Name: \_\_\_\_\_

2. Organization Contact Information (*use principal office address*):

\_\_\_\_\_  
Address Line 1

\_\_\_\_\_  
Phone Number of Principal Office

\_\_\_\_\_  
Address Line 2

\_\_\_\_\_  
Alternate Phone

\_\_\_\_\_  
City, State, Zip

\_\_\_\_\_  
Website

\_\_\_\_\_  
County

Organization Contact Information in California (*if different*):

\_\_\_\_\_  
Address Line 1

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Address Line 2

\_\_\_\_\_  
Alternate Phone

\_\_\_\_\_  
City, State, Zip

\_\_\_\_\_  
County

3. Type of Organization:

Is the organization operating pursuant to Section 501(c)(3) of the Internal Revenue Code?  
\_\_\_\_\_ Yes    \_\_\_\_\_ No

If not, is the organization a community-based organization\*?  
\_\_\_\_\_ Yes    \_\_\_\_\_ No

Organization's Tax Identification Number \_\_\_\_\_

If a community-based organization, please describe the mission, goals and activities of the organization (*attach separate sheet(s) if necessary*): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\* A "community based organization" means a public or private nonprofit organization that is representative of a community or a significant segment of a community, and is engaged in meeting human, educational, environmental, or public safety community needs.

**PART 2 – RESPONSIBLE ORGANIZATION OFFICIALS**

Please list the following information for each of the principal individual(s) who are the officers or officials of the organization responsible for operation of the sponsoring entity.

**Individual 1:**

_____ Name	_____ Title
_____ Address Line 1	_____ Phone
_____ Address Line 2	_____ Alternate Phone
_____ City, State, Zip	_____ E-mail address
_____ County	

**Individual 2:**

_____ Name	_____ Title
_____ Address Line 1	_____ Phone
_____ Address Line 2	_____ Alternate Phone
_____ City, State, Zip	_____ E-mail address
_____ County	

**Individual 3:**

_____ Name	_____ Title
_____ Address Line 1	_____ Phone
_____ Address Line 2	_____ Alternate Phone
_____ City, State, Zip	_____ E-mail address
_____ County	

*(Attach additional sheets if needed to list additional principal organizational individuals)*

**PART 3 – EVENT DETAILS**

1. Name of event, if any: \_\_\_\_\_

2. Date(s) of event (not to exceed ten calendar days): \_\_\_\_\_

3. Location(s) of the event (be as specific as possible, including address):  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4. Describe the intended event, including a list of all types of healthcare services intended to be provided (*attach additional sheet(s) if necessary*):  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

5. Attach a list of all out-of-state health care practitioners who you currently believe intend to apply for authorization to participate in the event. The list should include the name, profession, and state of licensure of each identified individual.

*Check here to indicate that list is attached.*

6. Please check each licensing authority that will have jurisdiction over an out-of-state licensed health practitioner who intends to participate in the event:

- |  |  |
|--|--|
| <input type="checkbox"/> Acupuncture Board               | <input type="checkbox"/> Physician Assistant Committee                                       |
| <input type="checkbox"/> Board of Behavioral Sciences    | <input type="checkbox"/> Physical Therapy Board  |
| <input type="checkbox"/> Board of Chiropractic Examiners | <input type="checkbox"/> Board of Podiatric Medicine   |
| <input type="checkbox"/> Dental Board                    | <input type="checkbox"/> Board of Psychology   |
| <input type="checkbox"/> Dental Hygiene Committee        | <input type="checkbox"/> Board of Registered Nursing   |
| <input type="checkbox"/> Medical Board                   | <input type="checkbox"/> Respiratory Care Board  |
| <input type="checkbox"/> Naturopathic Medicine Committee | <input type="checkbox"/> Speech-Language Pathology, Audiology & Hearing Aid Dispensers Board |
| <input type="checkbox"/> Board of Occupational Therapy   | <input type="checkbox"/> Veterinary Medical Board  |
| <input type="checkbox"/> Board of Optometry              | <input type="checkbox"/> Board of Vocational Nursing & Psychiatric Technicians               |
| <input type="checkbox"/> Osteopathic Medical Board       |  |
| <input type="checkbox"/> Board of Pharmacy               |  |

**Note:**

- Each individual out-of-state practitioner must request authorization to participate in the event by submitting an application (Form DBC- 901-B) to the Committee.
- The organization and the applicant will be notified in writing by the Committee whether authorization for an individual out-of-state practitioner has been granted.
- I understand the recordkeeping requirements imposed by California Business and Professions Code Section 901 and Title 16, California Code of Regulations Section 1023.16 to maintain records both at the sponsored event and for five (5) years in California.

- I understand that our organization must file a report with each applicable committee within fifteen (15) calendar days of the completion of the event.

This form, and any attachments, shall be submitted to:

\_\_\_\_\_ Department of Consumer Affairs  
Attn: Executive Office  
1625 North Market Blvd.  
Sacramento, CA 95834

\_\_\_\_\_ Dental Hygiene Committee of California  
Attn: Licensing & Examinations Unit  
2005 Evergreen Street, Suite 1050  
Sacramento, CA 95815

Questions regarding the completion of this form should be directed to: the Licensing and Examinations Unit of the Dental Hygiene Committee of California at the address listed above, or by phone or email as follows:

Phone: (916) 263-1978

I certify under penalty of perjury that the information provided on this form and any attachments is true and current and that I am authorized to sign this form on behalf of the organization:

\_\_\_\_\_  
Name Printed

\_\_\_\_\_  
Title

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**NOTICE OF COLLECTION OF PERSONAL INFORMATION**

Disclosure of your personal information is mandatory. The information on this form is required pursuant to Title 16, California Code of Regulations Sections 1023.16 and Business and Professions Code section 901. Failure to provide any of the required information will result in the form being rejected or denied as incomplete. The information provided will be used to determine compliance with Article 8 of Division 10 of Title 16 of the California Code of Regulations (beginning at Section 1023.15). The information collected may be transferred to other governmental and enforcement agencies. Individuals have a right of access to records containing personal information pertaining to that individual that are maintained by the Committee, unless the records are exempted from disclosure by Section 1798.40 of the Civil Code. Individuals may obtain information regarding the location of his or her records by contacting the Executive Officer at the Committee at the address and telephone number listed above.



## **REQUEST FOR AUTHORIZATION TO PRACTICE WITHOUT A LICENSE AT A REGISTERED FREE HEALTH CARE EVENT**

In accordance with California Business and Professions Code Section 901 any dental hygienist licensed/certified and in good standing in another state, district, or territory in the United States may request authorization from the Dental Hygiene Committee of California (Committee) to participate in a free health care event offered by a sponsoring entity, registered with the Committee pursuant to Section 901, for a period not to exceed ten (10) days. The Committee may deny requests for authorization received less than twenty (20) calendar days before the date on which the sponsored event will begin.

Note: If you are submitting fingerprint cards to the Committee ("Ink on Cards") along with your application, the Committee recommends that you submit your completed application package to the Committee at least 60 days prior to the scheduled event to assist in the timely processing of your fingerprint submissions through the California Department of Justice and Federal Bureau of Investigation.

### **PART 1 - APPLICATION INSTRUCTIONS**

An application must be complete and must be accompanied by all of the following:

- A processing fee of \$55.00, made payable to the Dental Hygiene Committee of California. If submitting fingerprint cards instead of using Live Scan, please submit an additional \$51 fee, payable to the Dental Hygiene Committee of California, to process your fingerprint cards for a total fee of **\$106.00**. See additional details below.
- A copy of each valid and current license and/or certificate authorizing the applicant to engage in the practice of dental hygiene issued by any state, district, or territory of the United States.
- A copy of a valid photo identification of the applicant issued by one of the jurisdictions in which the applicant holds a license or certificate to practice.
- Copies of Certificates of Completion showing at least 25 units of continuing education, including current CPR within two years of the date of this application.
- Any documents or statements requested on this application.
- Fingerprints. Fingerprints can be done with electronic Live Scan or ink on cards.

**Live Scan** is available only in California, for either residents or visitors, and is far speedier. The California Department of Justice (DOJ) has the form you need to complete and take to the Live Scan service location in California, and a list of the locations where it is obtainable (see [ag.ca.gov/fingerprints](http://ag.ca.gov/fingerprints)). The procedure is that you take the completed form to the service location, pay a fee and your fingerprints are taken on a glass without ink. The fingerprints are then transmitted electronically to the DOJ, and the DOJ sends the report to the Committee. Usually the report is received within two days. There is a low rate of rejections with this method.

**Ink on Cards.** If you are not able to come to California, you may contact the Committee to obtain a copy of California “Ink on Cards” to have fingerprints made – 2 cards. Other States’ resident Ink Cards will not be accepted. **Be sure to type or print legibly in black ink all the areas on both cards asking for personal information, that the cards are dated and signed by the official taking the fingerprints, and have your signature on them.** Include the 2 cards in your application with a \$51 non-refundable processing fee. Reports on some cards are received within a month after submission. Others may take many months due to needing to be repeated because of unreadable prints or other factors beyond the control of the Committee.

The Committee will not grant authorization until this form has been completed in its entirety, all required enclosures have been received by the Committee, and any additional information requested by the Committee has been provided by the applicant and reviewed by the Committee, and a determination has been made to grant authorization.

The Committee shall process this request and notify the sponsoring entity listed in this form if the request is approved or denied within 20 calendar days of receipt. If the Committee requires additional or clarifying information, the committee will contact you directly. Written approval or denial of requests will be provided directly to the sponsoring entity and to the applicant.

**PART 2 – NAME AND CONTACT INFORMATION**

1. Applicant Name: \_\_\_\_\_  
First Middle Last

2. Social Security Number: \_\_\_\_ - \_\_\_\_ - \_\_\_\_\_ Date of Birth: \_\_\_\_\_

3. Applicant’s Contact Information\*:

_____	_____
Address Line 1	Phone
_____	_____
Address Line 2	Alternate Phone
_____	_____
City, State, Zip	E-mail address

(\*If an authorization is issued, this address information will be considered your “address of record” with the Committee and will be made available to the public upon request.)

4. Applicant’s Employer : \_\_\_\_\_

Employer’s Contact Information:

_____	_____
Address Line 1	Phone
_____	_____
Address Line 2	Facsimile
_____	_____
City, State, Zip	E-mail address (if available)

**PART 3 – LICENSURE INFORMATION**

1. Do you hold a current license, certification, or registration issued by a state, district, or territory of the United States authorizing the unrestricted practice of dental hygiene in your jurisdiction(s)?

No  If no, you are not eligible to participate as an out-of-state practitioner in the sponsored event.

Yes  If yes, list every license, certificate, and registration authorizing you to engage in the practice of dental hygiene in the following table. If there are not enough boxes to include all the relevant information please attach an addendum to this form. Please also attach a copy of each of your current licenses, certificates, and registrations.

State/ Jurisdiction	Issuing Agency/Authority	License Number	Expiration Date

2. Do you possess valid certification according to committee requirements in periodontal soft tissue curettage, administration of nitrous oxide and oxygen and administration local anesthetic agents? Yes  No

3. CONTINUING EDUCATION. Provide copies of certificates of completion including CPR certification. Do not send originals.

4. Are you currently the subject of any investigation by any governmental entity? Yes  No   
If yes, provide a detailed explanation of the circumstances surrounding the investigation.

5. Have you ever had charges filed against a dental hygiene license that you currently hold or held in the past, including charges that are still pending? Yes No

If yes, provide a detailed explanation and a copy of the documents relating to the filing of charges.

6. Have you ever had any disciplinary action taken against a dental hygiene license or other healing arts license?  Yes No

Disciplinary action includes, but is not limited to, suspension, revocation, probation, confidential discipline, consent order, letter of reprimand or warning, or any other restriction or action taken against a dental hygiene license. If yes, provide a detailed explanation and a copy of all documents relating to the disciplinary action.

7. Have you ever surrendered a dental hygiene license, either voluntary or otherwise?

Yes  No

If yes, provide a detailed explanation and a copy of all documents relating to the surrender.

8. Have you ever been the subject of a malpractice settlement or judgment? Yes  No

If yes, provide a detailed explanation of the circumstances and outcome relating to the malpractice settlement or judgment. You may be required to provide additional information after review of your explanation.

**IMPORTANT REQUIREMENT:** If a disciplinary action is filed against any license you currently hold pending the Committee's decision on this application for authorization, you must notify the Committee in writing within 48 hours.

9. With the exception of conviction of an infraction resulting in a fine of less than \$1,000, have you ever been convicted of any crime, including an infraction, misdemeanor or felony? Yes  No

"Conviction" includes a plea of no contest and any conviction that has been set aside pursuant to Section 1203.4 of the Penal Code. Therefore, you must disclose any convictions in which you entered a plea of no contest and any convictions that were subsequently set aside pursuant to Section 1203.4 of the Penal Code.

10. Do you have a current physical or mental impairment related to drugs or alcohol?

Yes  No

11. Have you been adjudicated by a court to be mentally incompetent or are you currently under a conservatorship? Yes  No

If yes, provide a detailed explanation of the circumstances, date and time of the court order or the duration of the conservatorship.

#### **PART 4 – SPONSORED EVENT**

1. Name of non-profit or community-based organization hosting the free healthcare event (the "sponsoring entity"): \_\_\_\_\_

2. Name of event: \_\_\_\_\_

3. Date(s) & location(s) of the event: \_\_\_\_\_

4. Date(s) & location(s) applicant will be performing healthcare services (if different): \_\_\_\_\_

5. Please specify the healthcare services you intend to provide: \_\_\_\_\_

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6. Name and phone number of contact person with sponsoring entity: \_\_\_\_\_

**PART 5 – ACKNOWLEDGMENT/CERTIFICATION**

I, the undersigned, declare under penalty of perjury under the laws of the State of California and acknowledge that:

- I will comply with all applicable practice requirements required of licensed dental hygienists and all regulations of the Committee.
- In accordance with Business and Professions Code Section 901(i), I will only practice within the scope of my licensure and/or certification and within the scope of practice for California-licensed dental hygienists.
- I will provide the services authorized by this request and Business and Professions Code Section 901 to uninsured and underinsured persons only and shall receive no compensation for such services.
- I will provide the services authorized by this request and Business and Professions Code Section 901 only in association with the sponsoring entity listed herein and only on the dates and at the locations listed herein for a period not to exceed 10 calendar days.
- I am responsible for knowing and complying with California law and practice standards while participating in a sponsored event located in California.
- Practice of a regulated profession in California without proper licensure and/or authorization may subject me to potential administrative, civil and/or criminal penalties.
- The Committee may notify the licensing authority of my home jurisdiction and/or other appropriate law enforcement authorities of any potential grounds for discipline associated with my participation in the sponsored event.
- I have read the questions in the foregoing application and that all information provided by me in this application is true and complete to the best of my knowledge. By submitting this application and signing below, I am granting permission to the Committee to verify the information provided and to perform any investigation pertaining to the information I have provided as the Committee deems necessary.

**My signature on this application, or copy thereof, authorizes the National Practitioner Data Bank to release any and all information required by the Dental Hygiene Committee of California.**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Name Printed: \_\_\_\_\_

**NOTE:** Authorization will not be issued until clearance has been received from the California Department of Justice and the Federal Bureau of Investigation.

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