NMRLD
NEW MEXICO
REGULATION &
LICENSING DEPARTMENT

STATE OF NEW MEXICO
MICHELLE LUJAN GRISHAM, GOVERNOR
Linda M. Trujillo, Superintendent
John Blair, Deputy Superintendent

2021-2024 TRIENNIAL DENTAL ASSISTANT RENEWAL APPLICATION

Your Dental Assistant Certificate is **DUE TO RENEW** on **JUNE 30, 2021**. Print **clearly** in **black** ink or **type**.

Name: _____ **License #:** _____
Address: _____
_____

RENEWAL INFORMATION:
NMSA 1978, Section 24-14C-5(A) & (B) requires licenses of the New Mexico Board of Dental Health Care to complete a mandatory questionnaire to renew their license. **This is MANDATORY and your license WILL NOT BE RENEWED WITHOUT IT** which may result in late fees being assessed if not returned with your renewal application to the board office by June 30, 2021.

Renewal application *must* be postmarked no later than the DEADLINE DATE of JULY 1, 2021.
Due to the high volume of incoming mail and phone calls, please allow a minimum of TWO weeks for the Board Office to process your application. You can check the Board's Website (www.RLD.state.nm.us) using the "Licensee Search" to find out if your license has been renewed.

✓ **REVOCATION OF LICENSE FOR NON-RENEWAL: Unless an application for license renewal is received by the board office, or post-marked, before September 1, 2021 the license shall be revoked. (16.5.37.8 NMAC)**

✓ **LATE FEES: Late fees will be assessed for renewals postmarked after July 1, 2021.**

- **RENEWAL APPLICATIONS POST-MARKED AFTER JULY 1, 2021 AND PRIOR TO AUGUST 1, 2021: Late Fee of $25.00 + Renewal Fee of $50.00 = $75.00**

- **RENEWAL APPLICATIONS POST-MARKED ON OR AFTER AUGUST 1, 2021 BUT BEFORE SEPTEMBER 1, 2021: Late Fee of $25.00 + Reinstatement Fee of $15.00 + Renewal Fee of $50.00 = $90.00**

✓**CONTINUING EDUCATION REQUIREMENTS: Proof of Thirty (30) hours of continuing education is required for each triennial cycle. Continuing education requirements are pro-rated at ten hours per full year of the licensing period. SEE Title Chapter 5, Part 36 OF THE RULES FOR ADDITIONAL INFORMATION. • Radiographic technique or safety and protection (3 hours or more) • Infection Control (1 hour or more) • Current CPR/BLS Card (Cardiac Pulmonary Resuscitation/Basic Life Support); one credit counts for one (1) class hour.**
NOTE: 30 hours allowed of self-study

✓ **INCOMPLETE APPLICATIONS: Failure to submit the required information about continuing education, applicable fees, explanation to "yes" answers, and/or lack of original licensee signature.**
INCOMPLETE RENEWAL APPLICATIONS WILL NOT BE PROCESSED!

YOU MUST HAVE A CURRENT CERTIFICATE TO LEGALLY EXPOSE RADIOGRAPHS IN THE STATE OF NEW MEXICO. IN ORDER TO PERFORM CORONAL POLISHING AND APPLY TOPICAL FLUORIDE OR PLACE SEALANTS UNDER GENERAL SUPERVISION IN THE STATE OF NEW MEXICO YOU MUST BE CERTIFIED.

LICENSE RENEWAL STATUS OPTIONS: (Please check the applicable status).

____**ACTIVE**** ~ I request my license to remain on **active status**. Active **Renewal Fee of $50.00**

_____**I do not want to renew my license (Please check and return this renewal application)**

LICENSEE INFORMATION

The Board must be informed of current mailing and practice address(s) for all Dental Assistants.

Social Security # (last4 -digits only) -_____

Home Phone # (_____)_____ Cell Phone # (_____)_____ Emergency Contact Phone # (_____)_____;

Personal E-mail Address: _____

Practice Name & Address: _____

City: _____ State: _____ Zip Code: _____ Phone #: (_____) _____

Practice E-mail Address: _____

Note: If there is a change in name, proper documentation must be provided (Copy of marriage certificate, divorce decree or court order).

Name Change: _____

(First Name) (MI) (Last Name)

Address Change:

_____

City: _____ State: _____ Zip Code: _____

PLEASE ANSWER THE FOLLOWING QUESTIONS BY CHECKING THE APPROPRIATE BOX.

1. Do you currently practice dental assisting in the state of New Mexico? YES☐ NO☐

2. How many hours per week, average? ☐ Less than 8 ☐ 9-16 ☐ 17-24 ☐ 25-32 ☐ 33-40

3. Have you received an additional academic degree since your initial license was issued? YES☐ NO☐

Year: _____ Degree: _____

(If you answered YES to questions from 4-8 is YES, give a fully detailed explanation of the circumstances on a separate sheet of paper).

4. Have you received a deferred prosecution or judgment or been convicted of, or pled guilty or nolo contendere to a felony or misdemeanor (not including traffic violations) in any state, territory or district of the United States or a foreign country? **(Not previously reported to this Board)** YES☐ NO☐

5. Have you ever had any disciplinary action taken against your dental assisting certificate or any other professional license in any state? YES☐ NO☐

6. Within the past 3 years, have you been a defendant in a legal action involving professional liability (malpractice), had a professional liability claim paid in your behalf, or paid such a claim yourself? (If you have previously submitted information and it is on file, please disregard.) YES☐ NO☐

7. Do you have any medical condition that in any way limits, impairs or alters your ability to practice dental assisting with reasonable skill or safety? YES☐ NO☐

8. Do you take any medications or chemical substances that limits, impairs or alters in any way your ability to practice dental assisting? YES☐ NO☐

9. I have read and will abide by the Dental Health Care rules? YES☐ NO☐

10. AMALGAM SEPARATOR REQUIREMENT – Are you a licensed owner(s), operator(s) or designee(s) of a dental office? YES☐ NO☐

If yes, please please provide the following:

(1) dates of maintenance;_____

(2) dates separator contents were recycled; _____

(3) name of the staff or contractor performing the service _____

Are you in compliance with Part 58 Dental Amalgam Waste? YES☐ NO☐

11. Are you employed by a non-dentist owner? YES☐ NO☐

(If yes, include the name, address and phone number of the non-dentist owner or corporation, and the name of their immediate manager or supervisor. (16.5.9.9 NMAC)

Business Name: _____ Phone # (_____) _____

Address: _____

City: _____ State: _____ Zip Code: _____

Owner or Manager's Name: _____

CONTINUING EDUCATION RECORD

Thirty (30) hours of continuing education (CE) taken within the triennial renewal cycle are required for renewal (read 16.5.36 NMAC). **EACH CE course or seminar completed MUST be listed on this form. CAUTION: Your renewal will be returned if you do not FULLY list the information as requested.** The words "See Attached" will not be sufficient. If there is insufficient room below to list all CE's you completed, you may list the remainder on a separate sheet of paper and **attach the sheet** to this renewal form. **Note: ▪ Three (3) or more hours need to be in Radiographic technique or safety and protection (RHS), One (1) or more hours of Infection Control (OSHA), and current CPR/BLS Card (Cardiac Pulmonary Resuscitation/Basic Life Support); one (1) credit counts as one (1) class hour. NOTE: CPR/BLS MUST be a hands-on course. A maximum of thirty (30) credits per triennial period will be allowed for self-study. (16.5.1.15 NMAC)**

CONTINUING EDUCATION INSTRUCTIONS: LIST your continuing education below on the form – you do NOT have to submit copies of the certificates of completion, *unless you are being audited*. This form will be the only permanent record with the Board of your continuing education activities. It is recommended that you keep copies of your continuing education certificates for future reference if needed. NOTE: Continuing education records may be audited by the board at any time (see 16.5.36.10 NMAC).

Date	Course Title	Presenter	Sponsor	# of hrs.
Total Hours Submitted (Include hours listed on additional pages)				

On this date, I hereby certify that all of the above requested information is true and correct to the best of my knowledge.

Signed: Date:

Boards and Commissions Division | Board of Dental Health Care
P.O. Box 25101 | Santa Fe, NM 87504
(505) 476-4622 | rld.state.nm.us

EMERGENCY DEFERRAL ~ A licensee unable to fulfill the continuing education requirements may apply to the board for an emergency deferral for extenuating circumstances, please see **(16.5.1.7 NMAC)** of the requirements. A designee of the board may grant deferrals of up to four months.

INCOMPLETE RENEWAL APPLICATIONS WILL NOT BE PROCESSED

CHECKLIST:

- ❑ Check the applicable status
- ❑ Completed renewal application (**Must be postmarked no later than JULY 1, 2021**)
- ❑ Renewal Fee: Active - $50.00: (payable by check **OR** money order)
- ❑ List of Thirty (30) hours of continuing education
- ❑ Late fee(s) if renewal is postmarked after the **DEADLINE DATE of JULY 1, 2021**.

MANDATORY QUESTIONNAIRE

NMSA 1978, Section 24-14C-5(A) & (B) requires licenses of the New Mexico Board of Dental Health Care to complete a mandatory questionnaire to renew their license. **This is <u>MANDATORY</u> and your license <u>WILL NOT BE RENEWED WITHOUT IT</u>** which may result in late fees being assessed if not returned with your renewal application to the board office by June 30, 2021.

New Mexico License Number: _____

CURRENT WORK STATUS (Select all that apply)

☐ Practice in New Mexico

☐ Practice Medicine in another state: ☐ TX ☐ CO ☐ AZ ☐ Other

☐ Permanently or Temporarily Inactive in New Mexico

☐ Retired, but maintain an active license

☐ Retired and do not maintain an active license

☐ Current Resident of Fellowship Training

CURRENT ACTIVITIES

How many weeks per year do you practice in NM? _____

How many hours per week do you practice in NM? _____

For you practice in New Mexico, approximately what percent of your time was spent on the following activities (percentage of all selected activities should total 100%)

	Direct Patient Care
	Teaching/Precepting
	Research
	Healthcare Administration

	Other, please specify:_____

For Direct Patient Care, approximately what percent of your time was spent in the following types of facilities (percentage should total 100%)

	Hospital/Inpatient
	Outpatient/Clinic
	Mobile Services
	Other, please specify:_____

LOCATION OF EDUCATION AND TRAINING

	New Mexico	Other U.S. state or Canada	Foreign country	Not Applicable
Location of the high school from which you graduated:	☐	☐	☐	☐
Location of the undergraduate college or university from which you graduated:	☐	☐	☐	☐
Location of the licensure training from which you graduated:	☐	☐	☐	☐
Location of primary specialty training:	☐	☐	☐	☐
Location of secondary specialty training:	☐	☐	☐	☐

PRACTICE SPECIALTY(IES) IN WHICH YOU SPEND MOST OF YOUR PROFESSIONAL TIME

Primary Specialty: _____

% Patient care time for primary specialty: _____

Secondary Specialty: _____

% Patient care time for secondary specialty: _____

TRAINING AND CERTIFICATION

	Yes	No
Completed accredited residency programs for primary specialty?	☐	☐
Board certified/Certificate of Added/Special Qualifications for primary specialty?	☐	☐
Completed accredited residency programs for secondary specialty?	☐	☐
Board certified/Certificate of Added/Special Qualifications for secondary specialty?	☐	☐

HOSPITAL ADMITTING PRIVILEGES

Number of hospitals in New Mexico at which you have admitting privileges

☐ None ☐ One ☐ Two ☐ Three or more

REIMBURSEMENT: PAYMENT SOURCES

Primary source of payment for patient care (**select top 3**):

☐ Medicare
☐ Medicaid
☐ Tricare/VA/HIS
☐ Private Insurance
☐ Self-pay
☐ Bad Debt/Charity
☐ Other

☐ Do Not Know or Not Applicable
☐ Other:_____

% of patients with Medicare as their primary payer: _____
% of patients with Medicaid as their primary payer: _____
% of patients with Tricare/VA/HIS as their primary payer: _____
% of patients with Private Insurance as their primary payer: _____
% of patients with Self-pay as their primary payer: _____
% of patients with Bad Debt/Charity as their primary payer: _____
% of patients with Other as their primary payer: _____

Provide an approximate monetary value for the **uncompensated** patient care you provided during the last year for **emergency** services: [ ]

Provide an approximate monetary value for the **uncompensated** patient care you provided during the last year for **non-emergency** services: [ ]

PATIENT CARE PRACTICE LOCATIONS

For PRIMARY location of patient care:

PRIMARY patient care street address:	
PRIMARY patient care city/town:	
PRIMARY patient care state:	
PRIMARY patient care 5-digit zip code:	
Weekly PRIMARY patient care hours:	
Weekly PRIMARY number of patients:	

For SECONDARY location of patient care:

SECONDARY patient care street address:	
SECONDARY patient care city/town:	
SECONDARY patient care state:	
SECONDARY patient care 5-digit zip code:	
Weekly SECONDARY patient care hours:	
Weekly SECONDARY number of patients:	

PRACTICE SETTINGS

What best describes your PRIMARY location practice?

☐ Independent Practice
☐ Group practice-Employee/Staff
☐ Organizationally affiliated (ie University, or Health Plan staff)
☐ Hospital-Inpatient
☐ Hospital-Outpatient dept/satellite clinic
☐ Hospital-Emergency room
☐ Federal Qualified Health Clinic (FQHC)
☐ Nursing home/Home Health agency
☐ Private health center/clinic
☐ Public/Non-profit community health center (non-FQHC)
☐ Other licensed community clinic
☐ Military/VA health facility

- ☐ Indian Health Service clinic
- ☐ Locum tenens
- ☐ Multi-Specialty Practice-Employee/staff
- ☐ Nurse Managed Clinic
- ☐ Other (please specify): _____

What best describes your PRIMARY location practice size?

- ☐ Solo Independent Practitioner
- ☐ Solo Independent Practitioner + Intermediate
- ☐ Two Independent Practitioners
- ☐ Three or Four Independent Practitioners
- ☐ Five to Nine Independent Practitioners
- ☐ Ten or More Independent Practitioners

What best describes your SECONDARY location practice?

- ☐ Independent Practice
- ☐ Group practice-Employee/Staff
- ☐ Organizationally affiliated (ie University, or Health Plan staff)
- ☐ Hospital-Inpatient
- ☐ Hospital-Outpatient dept/satellite clinic
- ☐ Hospital-Emergency room
- ☐ Federal Qualified Health Clinic (FQHC)
- ☐ Nursing home/Home Health agency
- ☐ Private health center/clinic
- ☐ Public/Non-profit community health center (non-FQHC)
- ☐ Other licensed community clinic
- ☐ Military/VA health facility
- ☐ Indian Health Service clinic
- ☐ Locum tenens
- ☐ Multi-Specialty Practice-Employee/staff
- ☐ Nurse Managed Clinic
- ☐ Other (please specify): _____

What best describes your SECONDARY location practice size?

- ☐ Solo Independent Practitioner
- ☐ Solo Independent Practitioner + Intermediate
- ☐ Two Independent Practitioners
- ☐ Three or Four Independent Practitioners
- ☐ Five to Nine Independent Practitioners
- ☐ Ten or More Independent Practitioners

CURRENT PRACTICE CAPACITY

What describes your current patient care practice capacity?

- ☐ My practice is full: I cannot accept any new/additional patients
- ☐ My practice is nearly full: I can accept a few new/additional patients
- ☐ My practice is far from full: I can accept new/additional patients
- ☐ Not Applicable

MEANINGFUL USE OF HEALTH INFORMATION TECHNOLOGY (HIT) AND ELECTRONIC HEALTH RECORD (EHR) IN YOUR PRACTICE

Does your practice CURRENTLY have the following HIT/EMR capacity? (select all that apply)	
☐	Computerized Provider Order Entry (CPOE)
☐	E-Labs (Order, Retrieve and Store results)
☐	Create Registries (e.g. registry of patient with diabetes)
☐	Quality Reporting
☐	Record Demographics (e.g. patient race/ethnicity, insurance status)
☐	Patient access to electronic copy of health records
☐	E-Prescribing
☐	Patient timely access to labs, x-ray and other results
☐	Record Vital Signs (e.g. height, weight, blood pressure)
Does your practice PLAN TO HAVE IN THE NEXT YEAR? (select all that apply)	
☐	Computerized Provider Order Entry (CPOE)
☐	E-Labs (Order, Retrieve and Store results)
☐	Create Registries (e.g. registry of patient with diabetes)
☐	Quality Reporting
☐	Record Demographics (e.g. patient race/ethnicity, insurance status)
☐	Patient access to electronic copy of health records
☐	E-Prescribing
☐	Patient timely access to labs, x-ray and other results
☐	Record Vital Signs (e.g. height, weight, blood pressure)

REFERRAL DIFFICULTIES

Identify the specialties that you or your patients have the greatest difficulty scheduling/obtaining/arranging a timely appointment **when making referrals** (MARK UP TO 3 SPECIALTIES)

☐ Advanced practice certified chiropractor
☐ Social Worker
☐ Social Worker - Clinical Specialty
☐ Social Worker - Medical Specialty
☐ Social Worker - School Specialty
☐ Social Worker - Researcher
☐ Social Work - Community Organizer
☐ Social Work Administrator
☐ Dental Public Health
☐ Endodontic
☐ Oral and maxillofacial surgery
☐ Orthodontics and dento-facial orthopedics
☐ Oral pathology
☐ Pediatric dentistry
☐ Periodontology
☐ Acupuncturists
☐ Cardiology/Vascular Specialists

☐ Chiropractors
☐ Dermatology
☐ Diabetic Educators
☐ Gynecology (only)
☐ Endocrinology and Metabolism
☐ Primary Care - Internal Medicine, Family
☐ Practice, Pediatrics, Geriatrics
☐ Infectious Disease
☐ Mental Health Adult, Child and Adolescent
☐ Nephrology
☐ Neurology
☐ Nutritionists
☐ Occupational /Rehabilation-Physiary
☐ Medicine
☐ Oncology/Hematology
☐ Orthotists/Prosthetics
☐ Pain Management
☐ Physical Therapy
☐ Rheumatology
☐ Other - _____

RECRUITMENT EXPERIENCES

How would you describe your experience in recruiting:	Easy	Somewhat Difficult	Very Difficult	Not Known or Now Applicable
Physicians	☐	☐	☐	☐
Nurses	☐	☐	☐	☐
Nurse Practitioners	☐	☐	☐	☐
Physician Assistants	☐	☐	☐	☐
Other Health Professionals	☐	☐	☐	☐

DEMOGRAPHIC INFORMATION

Gender: ☐ Male ☐ Female

Hispanic, Latino or Spanish Origin: ☐ Yes ☐ No

Race (Select all that apply):

☐ White or Caucasian

☐ Black or African American
☐ Native American or Alaska Native
☐ Asian or Pacific Islander
☐ Other: _____

NEAR FUTURE PRACTICE PLANS

In the next 12 months I plan to (select all that apply):
☐ Retire from patient care
☐ Significantly reduce patient care hours
☐ Move my practice to another geographic location in New Mexico
☐ Move my practice out of New Mexico
☐ None of the above

If you are retiring, moving or reducing patient care hours in the next 12 months, what are the factors that led to that decision? (select all that apply)
☐ Age
☐ Geographic preference
☐ Health
☐ Practice Environment
☐ Lack of Job Satisfaction
☐ Gross Receipts Tax
☐ Increasing Administrative/Regulatory Burden
☐ Reimbursement Issues
☐ Other: _____
☐ N/A

PROFESSIONAL LIABILITY INSURANCE INCREASE THRESHOLDS
At what percent increase in your annual liability insurance above your current level would you consider:

Retiring from patient care?	%
Significantly reduce patient care hours?	%
Moving practice out of state?	%

MEDICARE PAYMENT DECREASE THRESHOLDS
At what percent decrease to your Medicare payment level would you consider:

Retiring from patient care?	%
Closing practice to NEW Medicare patients	%
Closing practice to ALL Medicare patients	%
Significantly reduce patient care hours?	%
Moving practice out of state?	%

When billing for services:
☐ Submit billing through own license
☐ Submit billing through someone else's license
☐ Submit billing through Group/Hospital ID
☐ Do not know
☐ Other (please specify): _____