



**DENTAL HYGIENIST VOLUNTEER CE
REQUEST FORM
2022 ODA-Sponsored GKAS Program**

Ohio law permits dental hygienists to earn continuing education credit for providing free hygiene services. You may be eligible to claim CE credit for your participation in a GKAS program if you provided hygiene services that are substantive in nature (clinical) and those services were provided without any remuneration to you or the sponsoring program. **Credit hours are awarded at a ratio of one credit hour of CE for each sixty minutes spent providing free hygiene services. Dental hygienists may earn up to eight credit hours of CE per biennium for volunteer service.**

To qualify for credit, please complete this form to document the type of donated treatment you have voluntarily provided through the GKAS program, the number of hours you provided the donated treatment, and the dentist under which you provided free care. The lower half of the form must be completed by a dentist who can verify the volunteer services took place and that no remuneration occurred. Please return the completed form to the Ohio Dental Association, 1370 Dublin Rd., Columbus, OH 43215, fax to (614) 486-0381 or email to AnnualSession@oda.org. Upon verification of the information contained on this form, the ODA will issue your CE slip to the address shown below. Incomplete forms will not be processed.

NOTE: Education and/or oral hygiene instruction GKAS programs are not considered clinical in nature and do not count toward CE credit.

Hygienist must complete this section fully:

First Name _____ Last Name _____
Hygiene License#: _____ Address: _____
City, State Zip _____ Phone number: _____
Hygienist number of volunteer hours of care: _____ Date(s) of patient services: _____
Hygienist services provided: ☐Prophy ☐X-rays ☐Fluoride Treatment ☐Sealant ☐Other _____
Site: Dental office/clinic name: _____

I attest that the information contained on this form is accurate and that I have not requested or received CE credit for these volunteer hours through any other sponsor. I understand that this information may be verified.

Hygienist signature _____ Date _____

Verifying dentist must complete this section fully:

Dentist First Name _____ Last Name _____
Has there been reimbursement of any kind (partial or full) for the services provided either through insurance, Medicaid, or other payment? ☐Yes ☐No
Has there been any compensation through salary or other means for the hygienist's time? ☐Yes ☐No

Dentist signature _____ Date _____

Ohio Revised Code 4745.04: "A licensing agency that licenses health care professionals shall permit a licensee to satisfy up to one-third of the licensee's continuing education requirement by providing health care services as a volunteer. A licensing agency that licenses health care professionals shall permit a licensee to earn continuing education credits at the rate of one credit hour for each sixty minutes spent providing health care services as a volunteer."