



ADA American Dental Association®

DENTAL HYGIENIST VOLUNTEER CE REQUEST FORM 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 six 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 dentist@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."

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