STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS

STATE AND CONSUMER SERVICES AGENCY • ARNOLD SCHWARZENEGGER, GOVERNOR
DENTAL HYGIENE COMMITTEE OF CALIFORNIA
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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_____
[]COMPLETE []INCOMPLETE DATE RETURNED_____
REVIEWED BY_____ DATE_____
INTERVIEW DATE _____ []IN PERSON []TELEPHONE
STATUS []IN COMPLIANCE [] NOT IN COMPLIANCE
COMMENTS_____
CASE NUMBER_____
DATE MAILED TO SACRAMENTO_____
[]1QTR []2QTR []3QTR []4QTR []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 ☐ RDHAI ☐ RDHEF ☐ EXPERATION DATE
RESIDENCE ADDRESS: NUMBER STREET CITY STATE ZIP CODE
PHONE # ☐ THIS IS A NEW ADDRESS
OFFICE ADDRESS NUMBER STREET CITY STATE ZIP CODE
PHONE # ☐ THIS IS A NEW ADDRESS
DAYS OF PRACTICE HOURS
ADDITIONAL OFFICE ADDRESS NUMBER STREET CITY STATE ZIP CODE
PHONE # ☐ 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: _____

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
	☐	☐			
	☐	☐			
	☐	☐			
	☐	☐			
	☐	☐			

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
_____	☐	☐	_____	_____	☐
_____	☐	☐	_____	_____	☐

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
_____	☐	☐	_____
_____	☐	☐	_____
_____	☐	☐	_____
_____	☐	☐	_____

* PLEASE ATTACH A LETTER FROM THE COMMUNITY SERVICE ORGASNIZATION

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 ½ 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 of 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)