

OHIO STATE DENTAL BOARD

77 South High Street, 17^h Floor · Columbus, Ohio 43215-6135

Phone: 614-466-2580 · Fax: 614-752-8995

www.dental.ohio.gov

Please mail this completed answer sheet and attached affidavit to the Ohio State Dental Board at the address listed above.

Name: _____ Date: _____

Address: _____ Social Security Number: _____

City, State, Zip: _____

The successful completion of this examination fulfills the Jurisprudence requirements for the Ohio State Dental Board for Hygienists. Each question has **one** correct answer. Mark the blank below the appropriate letter that corresponds to the correct answer. This examination is **open book**.

HYGIENE · JURISPRUDENCE EXAMINATION · 2012

- | | | | | | | | |
|---|---|----|---|----|---|----|---|
| 1 | A B C D E
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | 8 | A B C D E
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | 14 | A B C D E
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | 20 | A B C D E
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| 2 | A B C D E
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<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | 21 | A B C D E
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| 3 | A B C D E
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<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | 22 | A B C D E
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| 4 | A B C D E
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<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | 23 | A B C D E
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| 5 | A B C D E
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<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | 24 | A B C D E
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| 6 | A B C D E
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | 13 | A B C D E
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | 19 | A B C D E
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | 25 | A B C D E
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| 7 | A B C D E
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | | | | | | |

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AFFIDAVIT OF APPLICANT

I, _____, do hereby certify under oath the following:

I understand that this is an open book examination and the only authorized sources of assistance for completing this examination are Chapter 4715 of the Ohio Revised and Administrative Codes (Dental Practice Act).

I have read the Ohio Dental Practice Act in its entirety and have completed this examination without the aid or assistance of any individual or other unauthorized source.

I further understand that in accordance with Chapter 4715 of the Ohio Revised Code, the Board shall have the authority to refuse to grant a license or to revoke a license or to discipline a licensee upon a finding that the licensee or applicant has knowingly made misleading, deceptive, untrue or fraudulent representations in the practice of dentistry or on any document connected therewith.

Witnessed my signature, the _____ day of _____, 200__.

Signature of Affiant

Sworn to and subscribed before me this _____ day of _____, 200__.

Notary Public

My Commission Expires: _____