# APPLICATION FOR DENTIST/DENTAL HYGIENIST LIMITED LICENSURE

## PART I- PROFILE DATA FORM

[1] **APPLICATION METHOD:** Please check the box applicable to your proposed practice setting.
☐ *Non-Remunerated* (Volunteer - not paid for services). Must submit Fee Waiver Affidavit.
☐ *Remunerated* (Paid employee) **Total due: $305.00 – Dentist $105.00 – Dental Hygienist**

[2] List your full, legal NAME as it should appear on LIMITED license (no nicknames or shortened versions):

FIRST: MIDDLE: LAST:

[3] Have you ever changed your name through marriage or action of a court, or have you been known by any other name? *If "YES", give the name(s) and date(s) of changes below:* ☐YES ☐NO

| [4] **Social Security Number - Required (Enter on separate page provided in application)** | [5] City/State/Country of Birth: | [6] Date of Birth (m/d/yr) |
|---|---|---|

[7] MAILING Address (street address, city, state, ZIP):

| [8] Work Telephone Number: ( ) | [9] Alternate Telephone Number: ( ) |
|---|---|

| [10] Name of Dental/Dental Hygiene School you attended: | [11] Type of Degree:<br>☐ D.D.S.<br>☐ D.M.D.<br>☐ A.S. Other__________ | [12] Date Graduated: |
|---|---|---|

## PART II - LICENSURE DATA

[13] Please list below all licensure/certifications to practice dentistry/dental hygiene or any health-related profession in any jurisdiction in the U.S. territory, including, Florida, or foreign country that you current hold or have ever held, regardless of status.

| [14] State | [15] License Title | [16] License Number | [17] Original Issue Date | [18] Expiration Date | [19] License Status |
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Tallahassee, FL 32399-3258 • (850) 245-4474 Telephone
www.doh.state.fl.us/mqa/dentistry

## PART III - PRACTICE AFFIRMATION AND HISTORY

| | |
|---|---|
| [20] Do you affirm that you have practiced dentistry/dental hygiene as a licensed dentist/dental hygienist for at least ten years in the United States? | YES NO |
| [21] Do you affirm that you have retired or intend to retire from the practice of dentistry/dental hygiene? *Please give the date (m/d/yr) of actual or intended retirement:* | YES NO |
| [22] Do you affirm that you will practice only as specified in Rule 64B5-7.007, Florida Administrative Code, if granted a limited license in Florida? | YES NO |

[23] **List Place of Practice in Florida, if known.** The director of the agency or institution must submit a letter of intention to employ. Section 456.015, Florida Statutes, requires that within 30 days of any change of employment, the department must be notified of the new address and place of employment.

| [24] Place of Employment | [25] Location Address (street, city, state, and ZIP) | [26] Employment Setting (✓ one) |
|---|---|---|
| | | ☐ Public or non-profit agency<br>☐ Indigent or critical need populations within the state |

## PART IV - PERSONAL AND LICENSURE HISTORY

ALL OF THE FOLLOWING QUESTIONS MUST BE ANSWERED.
If you answer "YES" to ANY of the following questions, explain in full by addendum to the application. You must make a statement that includes, but is not limited to, the date(s), location(s), specific circumstances, practitioners and/or treatment involved, etc., pertaining to the "YES" answer. If you have been under treatment for a mental or physical illness or condition that affects your ability to practice dentistry/dental hygiene, you must request that each practitioner, hospital, and program involved in your treatment submit a full, detailed report of such to the board office. Any "YES" answer must be substantiated by either official documents sent directly to the board office from the respective state licensing board or official copies of court records. A "YES" answer is NOT an automatic cause for denial of licensure.

In addition to your submission of necessary documentation for any "YES" answer to these questions, your answers may result in your being referred to the Physicians Recovery Network (PRN) for evaluation. The PRN is a consultant to the State of Florida contracted to evaluate practitioners to ensure their ability to practice with reasonable skill and safety to the public. If you have any questions, the board staff may be able to assist you in determining whether the evaluation will be necessary in your case. Additionally, a personal appearance before the board may be requested in some cases, regardless of whether the PRN is involved.

*NOTE: Obtaining or attempting to obtain a license by bribery, fraud, or knowing misrepresentation is a violation of the Dental Practice Act and may result in the denial of licensure, suspension or revocation of license, and/or other penalty under section 466.028, Florida Statutes, or Rule Chapter 64B5-13, F.A.C.*

| | |
|---|---|
| [27] Have you ever been convicted of, or entered a plea of guilty, nolo contendere, or no contest to a crime in any jurisdiction other than a minor traffic offense? You must include all misdemeanors and felonies, even if adjudication was withheld by the court so that you would not have a record or conviction. Driving under the influence or driving while impaired is not a minor traffic offense for purposes of this question.<br>If yes, please list date, jurisdiction (state and county), offense, disposition, and all other relevant information On reverse side or an attached sheet | YES NO |
| [28] Have you been enrolled in, required to enter into, or participated in any drug and/or alcohol recovery program or impaired practitioner program for treatment of drug or alcohol abuse that occurred within the past five years? | YES NO |
| [29] Have you been treated for or had a recurrence of a diagnosed mental disorder that has impaired your ability to practice dentistry/dental hygiene within the past five years? | YES NO |
| [30] Were you admitted or directed into a program for the treatment of a diagnosed substance-related (alcohol/drug) disorder or, if you were previously in such a program, did you suffer a relapse within the last five years? | YES NO |
| [31] Have you been treated for or had a recurrence of a diagnosed substance-related (alcohol/drug) disorder that has impaired your ability to practice dentistry within the last five years? | YES NO |

| Question | YES | NO |
|---|---|---|
| [32] Pursuant to Section 456.0635(2), Florida Statutes, the following questions are being asked. If you answer yes to any of the following questions, explain on a separate sheet providing accurate details and submit copies of supporting documentation. | YES | NO |
| [33]a. Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under Chapter 409, Chapter 817, or Chapter 893, Florida Statutes; or 21 U.S.C. ss. 801-970 or 42 U.S.C. ss. 1395-1396? (If no, do not answer 33b.) | YES | NO |
| [33]b. Has it been more than 15 years prior to the date of this application since the sentence and completion of any subsequent period of probation for such conviction? | YES | NO |
| [33]c. Have you ever been terminated for cause from the Florida Medicaid Program pursuant to Section 409.913, Florida Statutes? (If no, do not answer 33d.) | YES | NO |
| [33]d. If you have been terminated but reinstated, have you been in good standing with the Florida Medicaid Program for the most recent five years? | YES | NO |
| [33]e. Have you ever been terminated for cause, pursuant to the appeals procedures established by the state or federal government, from any other state Medicaid program or the federal Medicare program? (If no, do not answer 33f and 33g) | YES | NO |
| [33]f. Have you been in good standing with a state Medicaid program or the federal Medicare program for the most recent five years? | YES | NO |
| [33g]. Did the termination occur at least 20 years prior to the date of this application? | YES | NO |
| [34] Have you ever been denied the right to take a Dentistry or Dental Hygiene examination in any state? | YES | NO |
| [35] Have you ever been refused a license to practice Dentistry, Dental Hygiene or any other license or the renewal thereof in any state? | YES | NO |
| [36] Have you ever had a license revoked or a certificate of registration to practice Dentistry, Dental Hygiene or any other licensed profession revoked, suspended or otherwise acted against (including probation, fine or reprimand) in a disciplinary proceeding in any state? | YES | NO |
| [37] Are you now or have you ever been a defendant in civil litigation in which the basis of the complaint against you was in alleged negligence, malpractice or lack of professional competence? | YES | NO |
| [38] Is there currently pending against you in any jurisdiction a complaint against your professional conduct or competence as a Dentist or Dental Hygienist or other licensed professional?<br>• If Questions 34-38 above are answered "YES", you must provide complete details as to state(s), license number(s), dates, and relevant circumstances on reverse side or on attached sheets. | YES | NO |

## PART V - APPLICANT RELEASE AND AFFIDAVIT

**THE FOLLOWING STATEMENT MUST BE COMPLETED:**

[39] **APPLICANT RELEASE AND AFFIDAVIT:**

I,______________________________________________, state that I am the person referred to in the foregoing limited licensure application and supporting documentation, that said application and any supporting documentation are true and accurate, and that the attached photograph is a true likeness of myself.

I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past and present), business and professional associates (past and present), and all governmental agencies and instrumentalities (local, state, federal and foreign) to release to the Florida Department of Health any information, files, or records requested by the agency in connection with the processing of this application. I further authorize the Florida Department of Health to release to any organization, individual or group listed above any information which is material to my application.

I understand that it is my responsibility to supplement my application as needed to reflect any material changes in any circumstance or condition stated in the application which might affect the decision of the department and which takes place between the initial filing of the application and the final granting or denial of limited licensure.

I understand that, once my limited license is granted, I may only practice in the employ of public agencies or institutions or nonprofit agencies or institutions which meet the requirements of s. 501(c)(3) of the Internal Revenue Code, and which provide professional liability coverage for my acts or omissions as the limited licensee. I also understand that, as a limited licensee, I may provide services only to the indigent or critical need populations within the state.

I have carefully read the instructions and questions in the foregoing application and have answered them completely, without reservations of any kind. Should I furnish any false information in this application, or in any supporting documentation, I acknowledge that such an act constitutes cause for denial, disciplinary action, suspension or revocation of my limited license to practice dentistry under Chapter 466, Florida Statutes, Chapter 456, Florida Statutes, and Chapter 64B5, Florida Administrative Code, in the State of Florida.

I hereby affirm that I have received, read and understood Chapter 466, Florida Statutes, Chapter 456, Florida Statutes, and Chapter 64B5, Florida Administrative Code, and acknowledge that I must abide by them.

Signature of Applicant:______________________________ Date signed________________

SWORN AND SUBSCRIBED BEFORE ME THIS __________ day of ______________________, __________.

In the County of______________________________ State of ______________________________

My commission expires on:______________________________

(notary stamp or seal)

Notary signature:______________________________

[40] We are required to ask that you furnish the following information as part of your voluntary compliance with Section 2, Uniform Guidelines on Employee Selection Procedure (1978) 43 FR39298 (August 25, 1978). This information is gathered for statistical purposes only and does not in any way affect your candidacy for licensure.

**Sex:** ☐ F ☐ M **Are you a US Citizen?** ☐ Yes ☐ No **If no, give alien number**______________________________

**Ethnic Origin:** ☐ Caucasian ☐ Black ☐ Hispanic ☐ Asian ☐ Native American ☐ Other____________________

# APPLICATION FOR DENTIST/DENTAL HYGIENIST LIMITED LICENSURE

## *INSTRUCTIONS*

## *SECTION I - APPLICATION PROCESS OVERVIEW*

**ELIGIBILITY REQUIREMENTS:**
**Statute and Rule References:**

- For licensure requirements, refer to section 456.015, Florida Statutes (F.S.), and rule 64B5-7.007, Florida Administrative Code (F.A.C.), copies of which can be printed at our website http:www.doh.state.fl.us/mqa/dentistry

**General Requirements and Information**

- The following criteria MUST be met in order to obtain dentist/dental hygienist limited licensure in Florida:
  - *The applicant has retired or intends to retire from the practice of dentistry/dental hygiene and intends to practice only pursuant to the restrictions of the limited license; AND*
  - *The applicant was licensed to practice dentistry/dental hygiene in any jurisdiction in the United States for at least 10 years.*

- The limited licensee can only practice in the employ of public agencies or non-profit agencies or institutions which meet the requirements of s. 501(c)(3) of the Internal Revenue Code, are permitted under rule 64B5-7.006 and which provide professional liability coverage for acts or omissions of the limited licensee.
- Limited licensees may provide services only to the indigent or critical need populations within the state.
- The laws and rules governing dental/dental hygiene practice in Florida can be printed at: http:www.doh.state.fl.us/mqa/dentistry

**Continuing Education Requirement:**

- Pursuant to rule 64B5-7.007(1)(d), F.A.C, the board shall require each applicant for limited licensure to complete each biennium (March 1st of every even numbered year through February 28th of every even numbered year) continuing education in compliance with rule 64B5-12, F.A.C. as following:

Dentist: 30 continuing education hours to include a 2 hour course in the prevention of medical errors every biennium. A course in HIV/AIDS is required no later than the first renewal and a 2 hour course in domestic violence is required every third biennum. In addition to the 30 continuing education hours, re-certification in CPR at the basic life support level and as defined in Rule 64B5-12.020, FAC.

Dental Hygienist: 24 continuing education hours to include 2 hour course in the prevention of medical errors. A course in HIV/AIDS is required no later than the first renewal and a 2 hour course in domestic violence is required every third biennium.

In addition to the 24 continuing education hours, re-certification in CPR at the basic life support level and as defined in Rule 64B5-12.020, FAC.

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## SECTION II - COMPLETING THE APPLICATION

**HELPFUL HINTS FOR APPLICATION COMPLETION:**

- ***KEEP THESE INSTRUCTIONS, THE LAWS AND RULES, AND A COPY OF THE COMPLETED APPLICATION FOR YOUR RECORDS.***
- ALL QUESTIONS MUST BE ANSWERED. If a question is not applicable, indicate such with N/A.
- When answering questions, do not refer to an attached resume. A resume may be submitted with the application; however, the questions in the application must be answered on the application form. Failure to do so will cause the application to be incomplete and the applicant will be requested to complete additional application pages, as applicable.
- The application must be completed in full and the affidavit and release signed by the applicant before a notary public.

**What to do if there is insufficient space in the application for a response:**

- If any of the sections in the application do not contain sufficient space for the requested information, use an additional sheet of paper and attach to the application.

  **Always number the additional information with the corresponding number of the question in the application.**

  Make a note on the application question that an addendum for that question is attached.

  ·PLEASE TYPE OR PRINT LEGIBLY ALL INFORMATION.

**WHERE TO SEND THE APPLICATION, FEE (IF APPLICABLE) AND ANY SUPPLEMENTAL INFORMATION**:

- The original application and fee should be mailed to the following address**: Department of Health, Post Office Box 6330, Tallahassee, FL 32314-6330.** *Make checks or money orders payable to **DOH-Board of Dentistry**.*

  **Any subsequent documents should be mailed to Department of Health, Board of Dentistry, 4052 Bald Cypress Way, Bin #C08, Tallahassee FL 32399-3258.**

- Verifications of licensure MUST be sent directly to the board office from the respective agency. Unofficial copies are NOT acceptable.
- **NOTE: THE BOARD OFFICE MUST BE NOTIFIED IMMEDIATELY OF ANYTHING WHICH CHANGES OR AFFECTS, IN ANY WAY, YOUR APPLICATION OR RESPONSES TO ANY QUESTION ON THE APPLICATION. FAILURE TO DO SO COULD RESULT IN THE DENIAL OF THE APPLICATION OR REVOCATION OF LICENSURE.**
  - EXAMPLES: CHANGE OF ADDRESS, EMPLOYMENT, LICENSURE OR DISCIPLINARY STATUS IN ANOTHER STATE, OR AN INCORRECT ANSWER TO A QUESTION.

## SECTION III - ITEM BY ITEM INSTRUCTIONS

*****PLEASE TYPE OR LEGIBLY PRINT ALL RESPONSES*****

*The following instructions address only those questions that are not self-explanatory. The instructions given are numbered so that they correspond with the numbered question in the application.*

**PART I. PROFILE DATA FORM.**

*This form must be submitted with the photograph attached in the spaces allowed.*

TAPE photograph in the space allowed on page 9 of the application. PRINT name on the back of the photograph. The photograph must be recent, be approximately 2" X 2" in size, and be of the head and shoulders ONLY. *Passport-type photographs are recommended.*

**Social Security Number:** Please complete the form found on the last page of this application package. Under the Federal Privacy Act, disclosure of social security numbers is voluntary unless specifically required by federal statute. In this instance, Social Security numbers are mandatory pursuant to Title 42 United States Code, Sections 653 and 654; and Sections 455.203(9), 409.2577, and 409.2598, Florida Statutes. Social Security numbers are used to

allow efficient screening of applicants and licensees by a Title IV-D child support agency to assure compliance with child support obligations. Social Security numbers must also be recorded on all professional and occupational license applications and will be used for licensee identification pursuant to the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Welfare Reform Act), 104 Pub. L 193, Section 317.

**Mailing address.** List the street address, city, state and ZIP CODE of your **preferred mailing address**. If a postal box, give the physical address as well by addendum to the application.

**PART II. LICENSURE DATA.**
**Licensure/certification in dentistry/dental hygiene or a related profession in any jurisdiction in the U.S.**
**Status of License/Certificate.** List the current status of each license/certificate; e.g., active; inactive; suspended; revoked; delinquent; etc.

- Applicant must request that licensure verification for each state licensure/certification be sent directly to the board office from the respective state board. *A copy of the license will NOT suffice.* The applicant is responsible for the payment of any fee required for verification of licensure/certification by another state. The verification must have the official seal of the state board affixed.
  - *The application will not be complete if this information is not received.*

**PART III. PRACTICE AFFIRMATION AND HISTORY**
List your place of practice in Florida, if known, indicating whether it is a public or non-profit agency or indigent or critical need populations area.

** Have the director of the agency or institution submit an original, signed, and currently dated letter to the department which outlines their intent to employ you as a limited licensee in their facility.*

**PART IV. PERSONAL/LICENSURE HISTORY.**
Each question must be answered YES or NO. Supporting documentation must be supplied for each YES answer. Upon review of the submitted documentation, the applicant will be notified if additional information or documentation is required. A “YES” answer to any of these questions may result in your being referred to the Physician’s Recovery Network (PRN) for evaluation. The PRN is a consultant to the State of Florida contracted to evaluate practitioners to ensure their ability to practice with reasonable skill and safety to the public. If you wish, you may contact the PRN on a self-referral basis prior to the submission of your application in order to begin the evaluation process. You may reach the PRN at (800) 888-8776.

**PART V. APPLICANT RELEASE AND AFFIDAVIT.**
This section must be completed and NOTARIZED in full as shown.

## LIMITED DENTIST/DENTAL HYGIENE LICENSE FEE WAIVER FORM

## TO BE COMPLETED BY EMPLOYER OR VOLUNTEER DENTIST/DENTAL HYGIENIST

Pursuant to Section 456.015, Florida Statutes and Rule 64B5-7.007, Florida Administrative Code, if a person applying for a limited license submits a notarized statement from the employing agency or institution stating that he/she will not receive monetary compensation for any services involving the practice of dentistry/dental hygiene, the licensure fees shall be waived.

***AFFIDAVIT***

I, ___________________________________________, being first duly sworn, state that the following dentist/dental hygienist:

_______________________________________________________________________________

TYPE OR PRINT DENTIST/DENTAL HYGIENIST'S NAME

will NOT receive monetary compensation for any service involving the practice of dentistry/dental hygiene from:

Agency/Institution: ___________________________________________

Address: _____________________________________________________

City/State/Zip: ______________________________________________

Signed: ___________________________________

Name (type or print): _______________________________

Title: ___________________________

STATE OF FLORIDA
COUNTY OF: ____________________________

The above person is personally known to me or has produced ________________ as identification.

SWORN AND SUBSCRIBED BEFORE ME
THIS _____________ DAY OF __________________, _____________
(month) (year)

(SEAL)

NOTARY PUBLIC: ________________________________________

MY COMMISSION EXPIRES: ______________________________



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# CONFIDENTIAL AND EXEMPT FROM PUBLIC RECORDS DISCLOSURE*

**Florida Department of Health**
**Board of Dentistry**

**Name:** ______________________________________________
**Last** **First** **Middle**

**Social Security Number:** ________________________________

*This page is exempt from public records disclosure. The Department of Health is required and authorized to collect Social Security Numbers relating to applications for professional licensure pursuant to Title 42 USCS s. 666(a)(13). For all professions regulated under chapter 456, Florida Statutes, the collection of Social Security Numbers is required by section 456.013(1)(a), Florida Statutes.

| TAPE 2" X 2" photo HERE must have been taken within 6 months of application<br><br>PROFESSIONAL QUALITY ONLY DEPICTING HEAD AND SHOULDERS<br><br>ONE PHOTO REQUIRED<br><br>print name on back of photo | **FLORIDA DEPARTMENT OF HEALTH**<br>***Board of Dentistry***<br>***Mailing Address for application and fees:***<br>***P.O. Box 6330***<br>***Tallahassee, FL 32314-6330***<br><br>***Mailing Address for supporting documents:***<br>***4052 Bald Cypress Way, Bin #C08***<br>***Tallahassee, FL 32399-3258***<br><br>*(850) 245-4474; Fax (850) 921-5389*<br>**NOTE:** PLEASE TYPE OR PRINT LEGIBLY IN BLACK INK. |
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