BOARD OF DENTISTRY

DENTAL LICENSURE APPLICATION

Department of Health
Florida Board of Dentistry
4052 Bald Cypress Way, #C-08
Tallahassee, FL 32399-3258
(850) 245-4474 Telephone – (850) 921-5389 Fax
http://www.doh.state.fl.us/mqa/dentistry
Email: MQA_Dentistry@doh.state.fl.us

Dental Licensure Application Instructions

Applicants are strongly encouraged to review s. 466.006, F.S. and Rule Chapter 64B5-2, F.A.C. prior to submitting this application. Excerpts of the statute that detail practice requirements are included on pages 5-7 of the instructions. The complete documents are located at the board's website: **www.doh.state.fl.us/mqa/dentistry**. Complete this application to apply for licensure after you have successfully completed the ADEX Dental Licensing Examination in its entirety, including the Diagnostic Skills Examination.

EXAMINATION REQUIREMENTS:

- Successful completion of the National Board Dental Examination (Part I and II)
- Successful completion of the ADEX Dental Licensing Examination administered in Florida; OR
- Successful completion of the ADEX Dental Licensing Examination in a jurisdiction other than Florida, if the examination was completed after October 1, 2011.
- Successful completion of the state Laws and Rules Examination. Applicants will be notified of their eligibility to take this examination upon receipt of a complete application.

EDUCATION REQUIREMENTS:

Graduation from a dental school accredited by the American Dental Association Commission on Dental Accreditation or its successor agency; OR

Graduation from a dental school not accredited by the Commission on Dental Accreditation of the American Dental Association and completion of a two (2) year supplemental dental education program at an American Dental Association accredited dental school. Specific requirements are defined in Rule 64B5-2.0146, F.A.C.

FEES:

Application fee	$	100.00
Development fee		80.00
Licensure fee		305.00* ($155 for applicants applying in second year of biennium
TOTAL FEE	**$**	**485.00**

Licensure biennium dates are March 1 – February 28 of the even years.

The fee must accompany the application. Please make check or money order payable to the **Department of Health** and mail application with fee and supporting documentation and credentials to:

DEPARTMENT OF HEALTH
P.O. BOX 6330
TALLAHASSEE, FLORIDA 32314-6330

Any supporting documentation and credentials mailed separately from the application should be mailed to:

DEPARTMENT OF HEALTH
BOARD OF DENTISTRY
4052 BALD CYPRESS WAY, BIN #C08
TALLAHASSEE, FLORIDA 32399-3258

IMPORTANT INFORMATION ABOUT THE COMPUTER BASED LAWS & RULES EXAMINATION:

Once the licensure application is received by the Board of Dentistry and determined to be complete, the Department's Testing Services Unit will notify the computer based testing vendor, Prometric, of applicant eligibility. You will receive a letter from the Board office to advise you that you can schedule the Laws and Rules Examination. Please be aware that an additional fee for the Laws and Rules Examination is payable to the vendor. The study material for the Laws and Rules Examination consists of the laws and rules booklet and is available at www.doh.state.fl.us/mqa/dentistry.

Applicants may view the Candidate Information Booklet for the Laws and Rules exam at the Testing Services website at www.doh.state.fl.us/mqa/exam.

REFUNDS

The application fee is non-refundable. Applicants who require board approval will be scheduled for an appearance at the next board meeting.

If an application is received without the fee attached, the application will automatically be returned. A social security number issued by the Federal Government is required for licensure. After completing the application, double check to make sure you have marked all questions as "yes" or "no" or not applicable. Also be sure to sign and date the application. If you answered, "yes" to question(s) 5A-C, 6A-E, and/or 11A-F, please submit all supporting documentation with the application.

CREDENTIALS:

All credentials must be mailed to the Board of Dentistry office at 4052 Bald Cypress Way, BIN #C08 Tallahassee, Florida 32399-3258.

(1) **National Board Score:** The Board office must receive proof of successful completion of the National Board Dental Examination. The scores must be mailed to our office from the American Dental Association.

(2) **Final Official Transcript:** Dental transcripts sent to the Board of Dentistry by the registrar's office with appropriate stamps, seals, degree, and signatures are necessary. ALL final transcripts must indicate the matriculation date, graduation date, degree earned, and be embossed with the school seal. We will not accept any transcript that has "issued to student" stamped on the transcript. Any transcript, which does not conform to these standards, shall be deemed unofficial and unacceptable.

(3) **Copy of Diploma:** A photocopy of your diploma will suffice.

(4) **Certification of Licensure:** Please submit certification of licensure from each state in which you **HOLD OR HAVE HELD** a dental or dental hygiene license. This certification should state that your license is in good standing; appropriate signatures and embossed seal of the certifying Board are needed for validation.

(5) **Prevention of Medical Errors Requirement:** Each applicant must complete a minimum two hour course in the prevention of medical errors from a Board of Dentistry approved provider. "Proof of completion" of this course must be in the form of a certificate or letter from the provider. We have attached an abbreviated provider list for your assistance. (Courses older than two years will not be accepted.)

(6) **CPR Certification:** Each applicant must provide proof of training in cardiopulmonary resuscitation (CPR) at the basic support level, including one-rescuer and two rescuer CPR for adults, children, and infants; the use of an automatic external defibrillator (AED); and the use of ambu-bags. All such training shall be sufficient for and shall result in current certification or recertification by the American Heart Association, the American Red Cross or an entity with equivalent requirements.

(7) **Other:** If you have changed your name in any way or added or deleted part of your name from the time you started your dental education, you must submit a copy of your name change document. If you do not have a name change document filed with the courts, submit a notarized affidavit stating the names are one and the same. Please notify the board office if you have documents being sent to us in another name.

If any question in section 5A-C, 6A-E, and/or 11A-F on the application is

answered “yes”, you must send all documentation filed with the courts, all letters/correspondence from the attorney explaining your situation, all letters from treating physicians, all information pertaining to any board of dentistry action taken against your license in another state, and any other information/documentation considered appropriate.

SPECIAL ACCOMMODATIONS:

Please visit the Testing Services website at www.doh.state.fl.us/mqa/Exam for an application if special testing accommodations are necessary.

ABBREVIATED PROVIDER LIST:

For your information and assistance, please note the abbreviated provider list to secure the appropriate PREVENTION OF MEDICAL ERRORS course. You may search free of charge for additional board approved courses at www.cebroker.com.

U.F. Continuing Education
(352) 273-8483

Health Studies Institute
1-800-700-3454

Please read s. 466.006, Florida Statutes, prior to submitting your application. Applicants who complete the ADEX examination in a jurisdiction other than Florida must complete additional requirements. Following is an excerpt from s. 466.006, F.S.

s. 466.006(6)(a) - It is the finding of the Legislature that absent a threat to the health, safety, and welfare of the public, the relocation of applicants to practice dentistry within the geographic boundaries of this state, who are lawfully and currently practicing dentistry in another state or territory of the United States, the District of Columbia, or the Commonwealth of Puerto Rico, based on their scores from the American Dental Licensing Examination administered in a state other than this state, is substantially related to achieving the important state interest of improving access to dental care for underserved citizens of this state and furthering the economic development goals of the state. Therefore, in order to maintain valid active licensure in this state, all applicants for licensure who are relocating to this state based on scores from the American Dental Licensing Examination administered in a state other than this state must actually engage in the full-time practice of dentistry inside the geographic boundaries of this state within 1 year of receiving such licensure in this state. The Legislature finds that, if such applicants do not actually engage in the full-time practice of dentistry within the geographic boundaries of this state within 1 year of receiving such a license in this state, access to dental care for the public will not significantly increase, patients’ continuity of care will not be attained, and the economic development goals of the state will not be significantly met.

(b)1. As used in this section, “full-time practice of dentistry within the geographic boundaries of this state within 1 year” is defined as a minimum of 1,200 hours in the initial year of licensure, which must include any combination of the following:

a. Active clinical practice of dentistry providing direct patient care within the geographic boundaries of this state.

b. Full-time practice as a faculty member employed by a dental or dental hygiene school approved by the board or accredited by the American Dental Association Commission on Dental Accreditation and located within the geographic boundaries of this state.

c. Full-time practice as a student at a postgraduate dental education program approved by the board or accredited by the American Dental Association Commission on Dental Accreditation and located within the geographic boundaries of this state.

2. The board shall develop rules to determine what type of proof of full-time practice of dentistry within the geographic boundaries of this state for 1 year is required in order to maintain active licensure and shall develop rules to recoup the cost to the board of verifying maintenance of such full-time practice under this section. Such proof must, at a minimum:

a. Be admissible as evidence in an administrative proceeding;

b. Be submitted in writing;

c. Be submitted by the applicant under oath with penalties of perjury attached;

d. Be further documented by an affidavit of someone unrelated to the applicant who is familiar with the applicant's practice and testifies with particularity that the applicant has been engaged in full-time practice of dentistry within the geographic boundaries of this state within the last 365 days; and

e. Include such additional proof as specifically found by the board to be both credible and admissible.

3. An affidavit of only the applicant is not acceptable proof of full-time practice of dentistry within the geographic boundaries of this state within 1 year, unless it is further attested to by someone unrelated to the applicant who has personal knowledge of the applicant's practice within the last 365 days. If the board deems it necessary to assess credibility or accuracy, the board may require the applicant or the applicant's witnesses to appear before the board and give oral testimony under oath.

(c) It is the further intent of the Legislature that a license issued pursuant to paragraph (a) shall expire in the event the board finds that it did not receive acceptable proof of full-time practice within the geographic boundaries of this state within 1 year after the initial issuance of the license. The board shall make reasonable attempts within 30 days prior to the expiration of such a license to notify the licensee in writing at his or her last known address of the need for proof of full-time practice in order to continue licensure. If the board has not received a satisfactory response from the licensee within the 30-day period, the licensee must be served with actual or constructive notice of the pending expiration of licensure and be given 20 days in which to submit proof required in order to continue licensure. If the 20-day period expires and the board finds it has not received acceptable proof of full-time practice within the geographic boundaries of this state within 1 year after the initial issuance of the license, then the board must issue an administrative order finding that the license has expired. Such an order may be appealed by the former licensee in accordance with the provisions of chapter 120. In the event of expiration, the licensee shall immediately cease and desist from practicing dentistry and shall immediately surrender to

the board the wallet-size identification card and wall card. A person who uses or attempts to use a license issued pursuant to this section which has expired commits unlicensed practice of dentistry, a felony of the third degree pursuant to s. 466.026(1)(b), punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

Applicants using ADEX scores completed after October 1, 2011 from a jurisdiction other than Florida that are older than 365 days must complete additional requirements as stated in s. 466.006(4)(b)3.

DIVISION OF MEDICAL QUALITY ASSURANCE BOARD OF DENTISTRY	APPLICATION FOR DENTAL LICENSURE	DO NOT WRITE IN THIS SPACE FOR OFFICE USE ONLY
1.		
Date of ADEX EXAM _____________ Location of ADEX Exam ___________		
2. APPLICANT PROFILE DATA	➢Please attach cashier's check or money order ➢Please print or type or Application will be returned	

Name:	Last First Middle	Primary Telephone: Area Code ( )	Business Telephone: Area Code ( )
Mailing Address	Street and No. Apt. No.	Social Security Number Required; enter on Page 11
	City State Zip	Place of Birth: (City, State, Country)
Practice Location	Street and No. Apt. No.	Have you ever changed your name through marriage or through action of a court, or have you ever been known by any other name? Yes No
	City State Zip	If yes, list name(s) and date(s) of change(s) below:

Height Weight Eye Color Hair Color U.S. Citizen Yes No

E-mail address (optional)

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 FR38296 (August 25, 1978). This information is gathered for statistical and reporting purposes only and does not in any way affect your candidacy for licensure.

RACE: Caucasian African-American Hispanic Asian Native American Other

SEX: Male Female

DATE OF BIRTH / /

3. APPLICANT EDUCATION AND EXAMINATION DATA

A. Name of Dental School you attended:	
Location City State Country	Did you Graduate? Yes No Results Pending Degree: Year graduated:

B. Colleges or universities other than Dental:

Location From (Date)____________To: (Date) ____________ Did you graduate? Degree:

- A final official transcript sent DIRECTLY from your school of Dentistry must be received by the Board of Dentistry before your application can be deemed complete.

C–1. Have you successfully completed the National Board Dental Examination?

Yes No Results Pending - If it is under another name, please give other name_____________________________________

- These results must be sent directly from the National Board of Dental Examiners to the Florida Board of Dentistry. The contact information is: 211 East Chicago Avenue, Chicago, Illinois 60611, (312) 440-2811.

FOR OFFICE USE ONLY DO NOT WRITE IN THIS SPACE		Staple one photo in this area
CATEGORY: ______________________________	**EXAM SITE:** ______________	
SCHOOL CODE: ___________________________	**EXAM DATE:** ______________	
EDUCATION:	**EXAM CODE:**	**DO NOT GLUE OR PASTE**

4. APPLICANT EXPERIENCE

A. Indicate below all the time spent in internship and residency. Continue on reverse if necessary.

Hospital (or other institution):	Location	From (Date):	To (Date)	Nature of Internship or Residency:

B. Indicate below all professional practice since your graduation from Dental School. Include military service, if any. Continue on reverse or on separate sheets if necessary.

Location of practice:	From (Date):	To (Date)	Nature of practice (Clinical, administrative, education):

5. APPLICANT HISTORY – GENERAL (ATTACH ADDITIONAL SHEETS IF NECESSARY)

A. 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.

- If yes, please list date, jurisdiction (state and county), offense, disposition, and all other relevant information on reverse side or an attached sheet — Circle Yes No

B. If you have any religious conflict that would interfere with you taking this examination on the dates indicated on the Board of Dentistry website, please contact our office in writing, explaining your situation. Yes No

C. 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.

1a. 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 1b.) Yes No

1b. 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

2a. Have you ever been terminated for cause from the Florida Medicaid Program pursuant to Section 409.913, Florida Statutes? (If no, do not answer 2b.) Yes No

2b. 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

3a. 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 3b and 3c.) Yes No

3b. Have you been in good standing with a state Medicaid program or the federal Medicare program for the most recent five years? Yes No

3c. Did the termination occur at least 20 years prior to the date of this application? Yes No

6. APPLICANT HISTORY – PROFESSIONAL LICENSURE

A. Have you ever been denied the right to take a Dentistry or Dental Hygiene examination in any state? Yes No

B. 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

C. 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

D. 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

E. Is there currently pending against you in any jurisdiction a complaint against your professional conduct or competence as a Dentist or Dental Hygienist? Yes No

- If Questions 6A, 6B, 6C, 6D or BE 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.

7. APPLICANT LICENSURE STATUS

A. Do you now hold or have you ever held a license to practice Dentistry or Dental Hygiene in any state, U.S. territory or foreign country? (List most recent first) Yes No If "YES", list ALL such licenses below

State: License # If license is not in force, how and when was validity ceased?

B. Do you have any applications for Dental or Dental Hygiene Licensure currently pending in any state or foreign country? Yes No If "YES", list ALL such state or jurisdictions below

8. OATH

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, or foreign) to release to the Florida Department of Health my information files or records requested by the department in connection with the processing of this application. I further authorize the Florida Department of Health to release to the organizations, individuals and groups 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 licensure. I understand that the application fee is non-refundable or transferable under any circumstances and that one half of the examination fee is refundable only if I am found to be ineligible by the board or I withdraw, in writing, at least 14 days prior to the examination date. I also understand that all dates and sites are subject to change at any time.

I have carefully read the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for the denial, suspension, or revocation of any license to practice in the State of Florida the profession for which I am applying.

Applicant Signature ____ Date ___________________________________

Before me, personally appeared ____, whose identity is known to me by ______________________________ (type of identification) and who, under oath, acknowledges that his signature appears above.

Sworn to and subscribed before me this ________ day of __________________. 20_______.

_____________________________________ NOTARY PUBLIC
My Commission Expires:

9. REMARKS

This section is for any additional information you would like to give us. Please refer to the section number (within the application) you are referring to. An example would be: #2, Applicant Profile Data.

CONFIDENTIAL AND EXEMPT FROM PUBLIC RECORDS DISCLOSURE*

Florida Department of Health
Board of Dentistry

10. 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 USCA 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.

11. - APPLICANT HISTORY - HEALTH

If you answer "YES" to any of the following questions, you must submit a current mental health status report from a licensed mental health professional, wherein this professional practitioner opines that you are able to practice with reasonable skill and safety to patients or clients.

Question	Answer
A. In the last 5 years, have you been enrolled in, required to enter into, or participated in any drug or alcohol recovery program or impaired practitioner program for treatment of drug or alcohol abuse that occurred within the past 5 years?	❑ YES ❑ NO
B. In the last 5 years, have you been admitted or referred to a hospital, facility or impaired practitioner program for treatment of a diagnosed mental disorder or impairment?	❑ YES ❑ NO
C. During the last 5 years, have you been treated for or had a recurrence of a diagnosed mental disorder that has impaired your ability to practice your profession within the past 5 years?	❑ YES ❑ NO
D. In the last 5 years, 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 5 years?	❑ YES ❑ NO
E. During the last 5 years, have you been treated for or had a recurrence of a diagnosed substance-related (alcohol/drug) disorder that has impaired your ability to practice your profession within the past 5 years?	❑ YES ❑ NO
F. During the last 5 years, have you been treated for or had a recurrence of a diagnosed physical disorder that has impaired your ability to practice your profession?	❑ YES ❑ NO

CERTIFICATE OF LICENSURE

Instructions: For your convenience, you may tear out this page and send it to the Secretary of the Board in the state(s) where you hold or have held a license. However, only certificates bearing the ORIGINAL signature of certifying authorities will be accepted by the Florida Board of Dentistry.

CERTIFICATION OF SECRETARY OF BOARD OF THE STATE
IN WHICH APPLICANT HOLDS OR HAS HELD A
DENTAL/DENTAL HYGIENE LICENSE
(Required of all previously licensed candidates)

I, ____

Secretary of ____
Official name of Board

hereby certify that ______________________________was granted State Certificate No. _______________

to practice ☐ Dentistry ☐ Dental Hygiene in the state of _________________________

on the ________________ day of _________________, 20_____, on the basis of ______________________

- I hereby certify that the said applicant is in good standing with this board and there have not been any disciplinary procedures against, or pending on, said applicant.

(SEAL)
NOT VALID WITHOUT
STATE SEAL

____
Secretary

- If disciplinary action has been taken, please indicate, and submit supporting information.

CERTIFICATION OF COURSE COMPLETION FOR PREVENTION OF MEDICAL ERRORS REQUIREMENT FOR DENTAL APPLICANTS

PLEASE MARK ONE

Applicant's Name: ____

Name should be the same as stated in exam application

Provider Name: ____

Provider Address: ____

Title of Course: ____

Date of Course: ____

Number of credit hours offered: ____________________________________

____ ____________________

Signature of Authorized Agent Date