



BOARD OF DENTISTRY

**HEALTH ACCESS DENTAL LICENSE
APPLICATION**



Definition from Chapter 466.003(14), F.S.

"Health access settings" means programs and institutions of the Department of Children and Family Services, the Department of Health, the Department of Juvenile Justice, nonprofit community health centers, Head Start centers, federally qualified health centers (FQHCs), FQHC look-alikes as defined by federal law, and clinics operated by accredited colleges of dentistry in this state if such community service programs and institutions immediately report to the Board of Dentistry all violations of s. 466.027, s. 466.028, or other practice act or standard of care violations related to the actions or inactions of a dentist, dental hygienist, or dental assistant engaged in the delivery of dental care in such settings.

Clarification of Chapter 466.006(2)(c)2.a., F.S.

At the September 11-12, 2008 Board meeting the Board interpreted "retired veteran dentist" as a dentist who has separated from the military.

REQUIREMENTS FOR HEALTH ACCESS DENTAL LICENSURE:

- the applicant has graduated from a dental school accredited by the Commission on Accreditation of the American Dental Association or its successor agency;
- proof of successful completion of the National Board dental examination
- proof of successful completion of a state or regional clinical dental licensing examination;
- holds a valid, active dental license in good standing which has not been revoked, suspended, restricted, or otherwise disciplined;
- proof of 30 hours of continuing education from a Florida Board of Dentistry provider;
- proof that applicant has engaged in the active, clinical practice of dentistry providing direct patient care for 5 years preceding the date of application; or proof of continuous clinical practice providing direct patient care since graduation;
- proof that applicant has not been reported to the National Practitioner's Data Bank
- has never failed the examination specified in s. 466.006, F.S.;
- has successfully completed the Florida laws and rules exam

Applicants are encouraged to review s. 466.0067, F.S., before submitting the application.

ABOUT THE LAWS AND RULES EXAMINATION

The Department of Health computer based testing vendor is Prometric. You are responsible for scheduling your examination with Prometric once you have received

approval from the Board office. The study material consists of the most recent Laws and Rules document located at www.doh.state.fl.us/mqa/dentistry. You will also need the Laws and Rules Candidate Information Booklet located at www.doh.state.fl.us/mqa/Exam. You will be required to pay Prometric an additional fee. Please review www.prometric.com and use the “Locate Test Center” map feature to identify the testing site(s) nearest to you.

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.

FEES

Application fee	\$ 100.00
Exam Development fee	80.00
Licensure fee	<u>305.00</u>
TOTAL FEE	\$ 485.00

Please make check or money order payable to the Department of Health and mail application and fee to:

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

All additional requests for supporting documentation and credentials that do not contain fees should be mailed to:

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

REFUNDS

The application fee is non-refundable under any circumstances.

CREDENTIALS

- (1) **National Board Score:** The Board office must receive proof of successful completion of the National Board of Dental Examiners examination (Parts I and

II). 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 copy of your diploma will suffice.
- (4) **Certification of Licensure:** You must submit certification of licensure from each state, District of Columbia, or a U.S. territory you **HOLD OR HAVE HELD** a dental license. This certification should state that your license is in good standing and must include method of licensure; appropriate signatures and embossed seal of the certifying Board are needed for validation. **DO NOT SEND A COPY OF YOUR LICENSE!**
- (5) **Prevention of Medical Errors Requirement:** Each applicant must complete a minimum of two hours in a Prevention of Medical Errors course from an approved Board of Dentistry provider. **"PROOF OF COMPLETION"** of this course must be in the form of a certificate or letter from the provider and must be completed within the past two years. Information regarding providers and courses can be viewed at www.cebroke.com.
- (6) **Self-query of the National Practitioner's Data Bank:** Please view <http://www.npdb-hipdb.com/welcomesq.html> for information on obtaining a self-query and submit this with your application.
- (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. If you have documents being sent to us in another name, we need to know. If you answered "yes" to any questions, please submit all supporting 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. All documentation must be official.

ABBREVIATED PROVIDER LIST:

For your information and assistance, following is an abbreviated provider list to assist you in securing the appropriate PREVENTION OF MEDICAL ERRORS course.

U.F. Continuing Education
(352) 273-8480

Health Studies Institute
1-800-700-3454

Additional information regarding approved continuing education providers as well as courses may be obtained at www.CEBroker.com.

Please contact the Board office at (850) 245-4474 or via email at MQA_Dentistry@doh.state.fl.us if you have any questions.



DIVISION OF MEDICAL QUALITY ASSURANCE BOARD OF DENTISTRY	APPLICATION FOR HEALTH ACCESS DENTAL LICENSE	DO NOT WRITE IN THIS SPACE FOR OFFICE USE ONLY		
1. APPLICANT PROFILE DATA				
➤Please attach check or money order ➤Please print or type or Application will be returned				
Name:	Last First Middle	Home Telephone: Area Code ()	Business Telephone: Area Code ()	
Mailing Address	Street and No. Apt. No.	Social Security Number: Enter on separate page provided in application		
	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? <input type="checkbox"/> Yes <input type="checkbox"/> 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 <input type="checkbox"/> Yes <input type="checkbox"/> 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: <input type="checkbox"/> Caucasian <input type="checkbox"/> African-American <input type="checkbox"/> Hispanic <input type="checkbox"/> Asian <input type="checkbox"/> Native American <input type="checkbox"/> Other		SEX: <input type="checkbox"/> Male <input type="checkbox"/> Female	DATE OF BIRTH / /	
2. APPLICANT EDUCATION AND EXAMINATION DATA				
A. Name of Dental School you attended:				
Location	City	State	Country	Did you Graduate? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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 you are allowed to take the examination.				
C. Have you successfully completed the National Board of Dental Examiners Dental Examination?				
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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. Their contact is: 211 East Chicago Avenue, Chicago, Illinois 60611, (312) 440-2811.				
FOR OFFICE USE ONLY DO NOT WRITE IN THIS SPACE				

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. Proof of a minimum of 5 years of clinical practice providing direct patient care is required for this license.

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. 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

C. Have you been treated for or had a recurrence of a diagnosed physical disorder that has impaired your ability to practice Dentistry within the past five years? Yes No

D. Have you been treated for or had a recurrence of a diagnosed mental disorder that has impaired your ability to practice Dentistry within the past five years? Yes No

E. 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

F. During the last five 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 Dentistry within the last five years? Yes No

- If yes to 5-B, 5-C, 5-D, 5-E or 5-F above, please show on reverse side or on additional sheets, the relevant dates and circumstances of such treatment along with the names and addresses of the medical practitioners who treated you.
- In addition, it will be necessary for you to direct each of the practitioners or hospitals who treated you to furnish the Board with any information regarding such treatment.

G. 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 failed the Florida dental exam? Yes No

C. 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

D. Have you engaged in the active, clinical practice of dentistry providing direct patient care for 5 years preceding the date of application; or have you engaged in the continuous clinical practice providing direct patient care since graduation? Yes No

E. 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

F. 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

G. 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

H. Have you ever been reported to the National Practitioner Data Bank? Yes No

➤ If Questions 6A, 6B, 6C, 6E, 6F, 6G or 6H 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 active, how and when did it become invalid?

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. AFFIDAVIT

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 the license granted by completion of this application is for work in health access settings only.

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 my license to practice dentistry in the State of Florida.

Applicant Signature _____ Date _____

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.

THE FIRST THREE PAGES OF THIS APPLICATION MUST BE RETURNED WITH THE FEE

REMINDER

ALL APPLICANTS MUST HAVE RECEIVED A CERTIFICATE FOR SUCCESSFULLY COMPLETING THE NATIONAL BOARD WRITTEN EXAMINATION

A copy of your scores should be sent directly from the ADA to this office. We will keep them on file at least two years.

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.

CERTIFICATE OF SECRETARY OF BOARD OF THE STATE
IN WHICH APPLICANT HAS OR HAS HELD A
DENTAL 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 _____

(specify examination, endorsement, other; also type of examination, i.e. clinical, written, other)

> 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.

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.