



Rick Scott  
Governor

**FLORIDA STATE BOARD OF DENTISTRY  
APPLICATION FOR TEMPORARY CERTIFICATE FOR EMPLOYMENT  
WITH A STATE OR COUNTY GOVERNMENT FACILITY  
Chapter 466.025(2), Florida Statutes  
Rule 64B5-7.0035, Florida Administrative Code**

Applications will be accepted only if completed by the state or county government facility Administrator/Director/Coordinator. Any questions not applicable must be indicated accordingly (N/A). The Board will not consider incomplete applications or faxed copies that are not legible. Copies may be made by the state or government facility as needed. This application is pursuant to the above statute and rule and/or any subsequent rule code. Please type or print all responses.

Name of State or County Government Facility \_\_\_\_\_

Address \_\_\_\_\_

Name of Administrator \_\_\_\_\_

Title of Administrator \_\_\_\_\_ Telephone Number (\_\_\_\_) \_\_\_\_\_

Name and license number of Florida licensed dentists(s) providing general supervision

Name \_\_\_\_\_ License Number \_\_\_\_\_

Name \_\_\_\_\_ License Number \_\_\_\_\_

\_\_\_\_\_  
Signature of Florida Licensed Dentist \_\_\_\_\_ Date \_\_\_\_\_

\_\_\_\_\_  
Signature of Florida Licensed Dentist \_\_\_\_\_ Date \_\_\_\_\_

The following information is required concerning the dentist working under the temporary certificate:

Name \_\_\_\_\_ SS# \_\_\_\_\_

Date of employment \_\_\_\_\_

Local mailing address \_\_\_\_\_

Telephone day ( ) \_\_\_\_\_ Telephone evening ( ) \_\_\_\_\_

Dental school attended \_\_\_\_\_



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Date graduated \_\_\_\_\_(ATTACH DIPLOMA OR FINAL OFFICIAL TRANSCRIPT)

Has the applicant failed the Florida State Board of Dentistry Dental Examination?

Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please indicate date \_\_\_\_\_

Is the applicant licensed as a dentist in any other state or jurisdiction? If yes, list state(s).

Yes \_\_\_\_\_ No \_\_\_\_\_

Have disciplinary actions been brought against applicant's license in another state or jurisdiction? If yes, provide final disposition documents.

Yes \_\_\_\_\_ No \_\_\_\_\_

Have malpractice actions been brought against applicant's license? If yes, provide final disposition documents.

Yes \_\_\_\_\_ No \_\_\_\_\_

Please attach copy as proof for the following courses:

- 1) Basic Life Support Level CPR certificate
- 2) Certificate of completion of HIV/Aids course

**I declare under penalty of perjury that the answers provided on this application are true and accurate. Furthermore, I certify on behalf of this state or county government facility that, should the temporary certificate holder be transferred or employment terminated, written notification will be forwarded to the Florida State Board of Dentistry within 30 days of the transfer or termination. This institution understands that any violation of Florida Statutes Chapter 466.027, 466.028 or Florida Administrative Code Rule 64B5-7.0035 is grounds for termination of the temporary certificate.**

\_\_\_\_\_  
Signature of Administrator

\_\_\_\_\_  
Date

Revised 01/07