States that grant limited license to international Dentist

Minnesota (MN)

Minnesota law allows internationally-educated dental graduates to apply for Minnesota licensure without additional education. There are no formal rules for the request for licensure process. The Board will review application materials on a case-by-case basis. Limited License: Graduates of non-accredited dental programs, who pass the clinical licensure examination and meet all other requirements, may obtain a three-year "limited general dentist license" permitting them to practice under general supervision pursuant to a written agreement with a Minnesota-licensed dentist. At the conclusion of three years, the board will grant an unlimited license without further restrictions if all supervising dentists who had entered into an agreement with the limited licensee recommend unlimited licensure and if no corrective or disciplinary actions have been taken by the Board against the limited licensee.

Ohio (OH)

Applicant must send a certified attestation, acceptable to the Board, from the faculty of an accredited dental college, that she/he completed a laboratory examination and clinical training in all phases of general dentistry, and that she/he possesses clinical skills at least equal to the graduates of that school. Since the vast majority of American dental schools do not offer a laboratory examination, and the laboratory examinations that are offered may not be accepted by the Ohio Board, it is recommended that the applicant enroll in a two-year program in an accredited dental school that includes clinical training, and which is commensurate with the final two years of dental school.

Massachusetts (MA)

Dental Limited License Registration: Applicants for licensure by applicants who have graduated from a non ADA accredited program may request limited license registration to provide dental services in a specific hospital, school, or government clinic which will sponsor the applicant. Practice in a private office is not permitted. Limited licensees must work under the supervision of a specified Massachusetts licensed dentist. Limited licenses are valid for one year and may be renewed for up to five years. To extend the license beyond the five year period the applicant is required to pass the examination administered by the North East Regional Examining Board (NERB). Faculty Practice Registration: When a foreign trained dentist has been appointed to the Faculty at a dental school he or she may apply for a faculty limited license. Faculty licenses are renewed on a yearly basis but unlike the limited license can be renewed indefinitely. As with limited licensees, faculty practice applicants are limited to a hospital, school, or clinic setting.

South Dakota (SD)

Must submit certification from an accredited dental school stating that the applicant has been tested and received whatever training necessary for the school to certify, in writing, that the applicant is equal in knowledge and ability to a graduate of an accredited dental school in the United States or Canada within the five years preceding the date of application.

Vermont (VT)

Must submit evidence of successful completion of a minimum of one year of study in a school of dentistry accredited by the Commission on Dental Accreditation of the American Dental Association, resulting in the awarding of a dental degree (D.D.S. or D.M.D.) by that institution.

Wisconsin (WI)

Must submit to the board evidence of graduation from a foreign dental school and evidence of the successful completion of an ADAaccredited postgraduate program in advance education in general dentistry (AEGD) or a general practice residency (GPR). The program can be either one or two years in length. Completion of a minimum of two years in an accredited dental program that results in a DDS or DMD is also accepted.

The Commonwealth of Massachusetts
Division of Health Professions Licensure
Board of Registration in Dentistry
239 Causeway Street, 5th floor, Suite 500
Boston, MA 02114
(617) 973-0971
www.mass.gov/dph/boards/dn

INITIAL (FIRST-TIME) DENTAL INTERN LIMITED LICENSE APPLICATION INSTRUCTIONS

(See 234 CMR 4.05 Effective August 20, 2010)

A Dental Intern Limited License allows you to perform all the duties of a dentist but only in a specifically named prison, hospital, school, or public clinic under the supervision of a dentist registered in accordance with M.G.L. Chapter 112, Section 45. **Practice in a private office is not permitted. Dental Intern Limited Licenses are valid for one (1) year from date of issue**

Please Note: A licensee who has been initially issued a limited dental intern license by the Board pursuant to M. G. L. c. 112, § 45A may apply to the Board annually to renew his/her limited license(s) for a maximum of five one-year periods, except that said licensee may, upon permission of the Board, take the NERB Clinical Examination in Dentistry (CED) or successor examination required by the Board. A limited license dental intern who successfully completes and passes the NERB /CED may thereafter apply to the Board annually to renew his/her license to practice dentistry in the Commonwealth in settings specified in M.G. L. c.112, § 45A and in compliance with 234 CMR 8.02(2).

The Board may approve a limited license provided the following documentation is received.

- An accurate, complete, and signed application including CORI request form.
- Applicant must have secured employment before applying for the license.
- Payment of a non-refundable licensing fee
- Proof satisfactory to the Board that the applicant has received a diploma in dentistry. Graduates of non-CODA or foreign dental schools shall submit an original transcript, with college seal that indicates the date of issuance of a dental diploma from a reputable dental college. If the transcript is not in English, the applicant shall provide a certified translated copy of the original dental college transcript demonstrating the applicant received a dental degree from a reputable dental college.
- Documentation demonstrating current certification in American Red Cross Cardiopulmonary Resuscitation/Automated External Defibrillation for the Professional Rescuer (CPR/AED) or current certification in the American Heart Association Basic Life Support for Healthcare Providers (BLS).
- If the applicant has graduated from a dental school where the language of written or oral instruction (including textbooks) or both, is in a language other than English, the applicant shall submit documentation satisfactory to the Board that the applicant has achieved a minimum score on TOEFL or IELTS.

- A physician's statement that is the result of an examination, conducted within six months of the date of application, attesting to the health of the applicant and reporting impairments which may affect the applicant's ability to practice dentistry.
- Certified letters of standing from all jurisdictions in which the applicant has ever been issued a license to practice dentistry attesting to the standing of his/her license, including report of any past or pending disciplinary action, or any pending complaints against the applicant.
- A practice history, if applicable.
- An original report from the National Practitioner Data Bank (NPDB) Self-query.
- A statement disclosing any disciplinary action, civil and/or criminal action taken against the applicant at any time prior to the date of application, with supporting documentation as may be required by the Board.
- Proof satisfactory to the Board of good moral character.
- Successful completion of the Massachusetts Dental Ethics and Jurisprudence Examination. Email the Board at dentistry.admin@state.ma.us to request a copy of the exam.
- Attach a passport-size photograph in color (2x2) to application where indicated. See http: travel.state.gov passport/guide composition/composition 874.html
- An affidavit, signed under pains and penalties of perjury, and witnessed by a Notary Public.

PLEASE NOTE:

- Incomplete applications will delay license processing.
- Please retain a copy of all application materials for your records.
- Upon board approval, a certificate and a license number will be issued in your name and sent to your supervising dentist. Confirmation of your license number will be available under "Online services/Check a License" on our website www.mass.gov dph boards dn as soon as the Board approves the license.
- See other public health sites, clinics, faculty, and/or educational opportunities

Hospitals	**www.mahospitalcareers.com**
Community Health Centers	www.massleague.org
Massachusetts Department of Corrections	www.mass.gov/doc
Harvard University School of Dental Medicine	www.hsdm.harvard.edu
Boston University Goldman School of Dental Medicine	www.bu.edu/dental/
Tufts University School of Dental Medicine	www.tufts.edu dental

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BOARD USE ONLY

Receipt #

Fee :

Jurisprudence: Pass Fail

APPLICATION
INITIAL(FIRST- TIME) DENTAL INTERN LIMITED LICENSE

1. APPLICANT NAME :
(Last) (First) (Middle)

2. MAIDEN NAME OTHER NAME :

3. ADDRESS OF RECORD:
(No.) (Street) (Apt #) (City or Town) (State or Country) (Zip Code)

Note: The address of record may be home or business and is, by law, public information.

4. MOST RECENT PREVIOUS ADDRESS:

5. TELEPHONE NUMBER AND EMAIL ADDRESS: Day: Cell:

Email Address:

6. EYE COLOR:
Date of Birth (mm dd yyyy) Place of Birth (city state country)

HEIGHT: Feet Inches WEIGHT: Lbs. MOTHER'S MAIDEN NAME :

7. SOCIAL SECURITY NUMBER (SSN) **(disclosure is mandatory):**
Pursuant to M.G.L. c. 62C, s. 47A, the Division of Health Professions Licensure is required to obtain your SSN and forward it to the Massachusetts Department of Revenue. The Department of Revenue will use your SSN to ascertain whether or not you are in compliance with Massachusetts tax laws (M.G.L. c. 62C, s. 47A) and child support laws (M.G.L. c. 119A, s.16).

EDUCATION

8. GRADUATE OF:

Name of Dental School

City State Province Postal Code Country

9. DATE DENTAL DEGREE CONFERRED DATE DEGREE
MM DD YYYY

ALL APPLICANTS MUST ATTACH:

AN OFFICIAL TRANSCRIPT OF ORIGINAL DEGREE OR LETTER FROM YOUR DENTAL SCHOOL INCLUDING DATE (MONTH, DAY, YEAR) OF GRADUATION AND DEGREE CONFERRED; AND,

IF APPLICABLE, AN ACADEMIC CREDENTIALS EVALUATION IN ENGLISH.

VERIFICATION OF OTHER LICENSES/BOARD REGISTRATIONS

10. LIST BELOW ALL PROFESSIONAL LICENSES OR REGISTRATIONS-- INCLUDING PROFESSIONS OTHER THAN DENTISTRY WHETHER OR NOT YOU HAVE PRACTICED UNDER THAT LICENSE OR REGISTRATION.

NOTE: Applicants must obtain official verification of each professional license or registration from each state or jurisdiction and submit it with this application.

☐ **I DO NOT CURRENTLY HOLD AND HAVE NEVER HELD A PROFESSIONAL LICENSE OR CERTIFICATION IN ANY STATE OR JURISDICTION**

[ ] **I CURRENTLY HOLD AND HAVE A PROFESSIONAL LICENSE OR REGISTRATION AS FOLLOWS:**

Issuing Jurisdiction Profession License Certification Number

PRACTICE LOCATION(S)

II. (A). NAME OF SPONSORING INSTITUTION CLINIC

ADDRESS

PHONE # PRACTICE TO BEGIN:

MM DD YYYY

SUPERVISING DENTIST NAME

MASSACHUSETTS DENTAL LICENSE #DN

I CERTIFY, UNDER PAINS AND PENALTIES OF PERJURY, THAT THE INFORMATION I HAVE PROVIDED PURSUANT TO THIS APPLICATION FOR LICENSURE IS TRUTHFUL AND ACCURATE.

SUPERVISING DENTIST SIGNATURE

II. (B). OTHER AFFILIATED PRACTICE LOCATIONS

ADDRESS

PHONE # PRACTICE TO BEGIN:

MM DD YYYY

SUPERVISING DENTIST NAME

MASSACHUSETTS DENTAL LICENSE #DN

I CERTIFY, UNDER PAINS AND PENALTIES OF PERJURY, THAT THE INFORMATION I HAVE PROVIDED PURSUANT TO THIS APPLICATION FOR LICENSURE IS TRUTHFUL AND ACCURATE.

SUPERVISING DENTIST SIGNATURE

II. (C). OTHER AFFILIATED PRACTICE LOCATIONS

ADDRESS

PHONE # PRACTICE TO BEGIN:

MM DD YYYY

SUPERVISING DENTIST NAME

MASSACHUSETTS DENTAL LICENSE #DN

I CERTIFY, UNDER PAINS AND PENALTIES OF PERJURY, THAT THE INFORMATION I HAVE PROVIDED PURSUANT TO THIS APPLICATION FOR LICENSURE IS TRUTHFUL AND ACCURATE.

SUPERVISING DENTIST SIGNATURE

ATTESTATION OF COMPLIANCE WITH 234 CMR 4.05 (5) EDUCATION REQUIREMENTS

12. CHECK THE APPLICABLE BOX BELOW, THEN SIGN TO INDICATE YOUR CERTIFICATION OF THE CHECKED STATEMENT. THE SIGNATURE OF THE SUPERVISING DENTIST IS ALSO REQUIRED ON THIS PAGE.

☐ I certify, under pains and penalties of perjury that I have completed or shall complete, within one year of the date of initial licensure, all of the following continuing education units (CEUs):

A minimum of 3 CEU's in *CDC Guidelines*;
A minimum of 3 CEU's in OSHA Standards at 29 CFR;
A minimum of 6 CEU's in treatment planning and diagnosis;
A minimum of 3 CEU's in record-keeping;
A minimum of 2 CEU's in risk management; and
A minimum of 3 CEU's in pharmacology with emphasis on prescription writing;

OR

☐ I certify, under pains and penalties of perjury that I am enrolled in a CODA-accredited dental school academic program that includes all areas of study listed above.

NAME OF SCHOOL

GRADUATION YEAR

REQUIRED SIGNATURES:

SIGNATURE OF APPLICANT

SIGNATURE OF SUPERVISING DENTIST AS WITNESS TO APPLICANT'S ATTESTATION

GOOD MORAL CHARACTER QUESTIONS

IF YOU ANSWER "YES" TO ANY OF THE FOLLOWING QUESTIONS PLEASE ATTACH A SEPARATE SHEET EXPLAINING THE CIRCUMSTANCES. ALSO PROVIDE ALL RELEVANT CERTIFIED DOCUMENTATION (POLICE REPORTS, COURT RECORDS, DISCIPLINARY ACTION REPORTS, ETC.) INCLUDING FINAL DISPOSITION OF THE MATTER.

13. Have you ever applied for and been denied a professional license in the United States or any country or foreign jurisdiction?

Yes ☐ No ☐

14. Has any licensing or certification board, government authority, hospital or health care facility or professional medical association located in the United States or any country or foreign jurisdiction taken any disciplinary action against you?

Yes ☐ No ☐

15. Are you the subject of pending disciplinary actions by any licensing or certification board, government authority, hospital or health care facility or professional medical association located in the United States or any country or foreign jurisdiction?

Yes ☐ No ☐

16. Have you ever voluntarily surrendered any professional license or board certification in the United States or any country or foreign jurisdiction?

Yes ☐ No ☐

17. Have you ever been arrested, charged, arraigned, indicted, prosecuted, convicted or been the subject of any criminal investigation or any court proceeding in relation to any criminal violation? Do not report minor violations for which a fine of $100 or less was imposed.

Yes ☐ No ☐

RELEASE

I hereby authorize all hospitals, institutions, credentialing agencies, organizations, personal physicians, employers (past and present), business and dental associates (past and present), and all government agencies and entities (local, state, federal, or foreign) to release to the Board of Registration in Dentistry any information, files or records requested by the Board in connection with the processing of my application. I further authorize the Board of Registration in Dentistry to release information contained in this application in association with its processing.

AFFIDAVIT OF APPLICANT

To the best of my knowledge and belief, I have filed all state tax returns and paid all state taxes required by state law and do not owe child support. I am aware of my professional obligations under M.G.L. c. 119 s. 51A, the reporting of suspected child abuse.

I understand that the Board is certified by the Massachusetts Criminal History Systems Board for access to Criminal Offender Record Information (CORI), including conviction and pending criminal case data. As an applicant for a license to practice as a limited licensed dentist I understand that a CORI check may be conducted by the Board for conviction and pending criminal case information only and that the CORI results will not necessarily disqualify me.

I understand that I am responsible for reading and understanding the laws and regulations governing practice as a limited licensed dentist in Massachusetts and I hereby agree to comply with such laws and regulations.

I understand that this application for licensure shall be deemed no longer valid if requirements for licensure as a limited licensed dentist are not met within one (1) year from the date of Board receipt. I also understand that fees are non-refundable and non-transferable.

I certify, under the pains and penalties of perjury, that the information I have provided pursuant to this application for licensure is truthful and accurate. I understand that any failure to provide truthful and accurate information in connection with this application for licensure may be grounds for the Board of Registration in Dentistry to deny issuance of a license; to suspend or revoke a license issued to me; and to deny renewal of a license issued to me, all in accordance with Massachusetts law.

To be completed, signed and witnessed by the applicant and a Notary Public.

APPLICANT SIGNATURE DATE

PRINT NAME

Attach a recent color 2"x 2" passport-sized Photo

NOTARY PUBLIC NAME:

NOTARY PUBLIC COMMISSION EXPIRES: [Seal or Stamp]

SUBMIT A NONREFUNDABLE AND NONTRANSFERABLE FEE FOR $90 (CHECK OR MONEY ORDER) PAYABLE TO THE COMMONWEALTH OF MASSACHUSETTS

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CRIMINAL OFFENDER RECORD INFORMATION (CORI) ACKNOWLEDGEMENT FORM

TO BE USED BY ORGANIZATIONS CONDUCTING CORI CHECKS FOR EMPLOYMENT, VOLUNTEER, SUBCONTRACTOR, LICENSING, AND HOUSING PURPOSES.

The Board of Registration in Dentistry is registered under the provisions of M.G.L. c. 6, § 172 to receive CORI for the purpose of screening current and otherwise qualified license applicants and current licensees.

As a prospective or current license applicant or current licensee, I understand that a CORI check will be submitted for my personal information to the Department of Criminal Justice Information Systems (DCJIS). I hereby acknowledge and provide permission to the Board of Registration in Dentistry to submit a CORI check for my information to the DCJIS. This authorization is valid for one year from the date of my signature. I may withdraw this authorization at any time by providing written notice of my intent to withdraw consent to a CORI check.

FOR EMPLOYMENT, VOLUNTEER, AND LICENSING PURPOSES ONLY:

The Board of Registration in Dentistry may conduct subsequent CORI checks within one year of the date this Form was signed by me provided, however, that Board of Registration in Dentistry must first provide me with written notice of this check.

By signing below, I provide my consent to a CORI check and acknowledge that the information provided on Page 2 of this Acknowledgement Form is true and accurate.

SIGNATURE

DATE

NOTE: The Board of Registration in Dentistry cannot accept this form unless it is either (1) signed in person at the Board's offices in the presence of a DHPL employee who has verified the applicant's identity through acceptable identification, or (2) signed in the presence of a notary public who has likewise verified identity and then mailed or hand-delivered to the Board's offices at the address set forth above.

CRIMINAL OFFENDER RECORD INFORMATION (CORI) ACKNOWLEDGEMENT FORM

SUBJECT INFORMATION: (An asterisk (*) denotes a required field)

*Last Name *First Name Middle Name Suffix

Maiden Name (or other name(s) by which you have been known)

*Date of Birth Place of Birth

*Last Six Digits of Your Social Security Number: -

Sex: Height: ft. in. Eye Color: Race:

Driver's License or ID Number: State of Issue:

Mother's Full Name (Mother's Maiden Name) Father's Full Name

Current and Former Addresses:

Street Number & Name City Town State Zip

Street Number & Name City Town State Zip

The above information was verified by reviewing the following form(s) of government-issued identification:

VERIFIED BY: ON

Name of Verifying DHPL Employee (Please Print) Date

Signature of Verifying DHPL Employee OR Notary Public

NOTARY NAME:

COMMISSION EXPIRES: [Seal or stamp]

ATTACHMENT CHECKLIST

Your application cannot be processed without all of the following.

Attachment 1: Licensing Fee - Personal or business check or money order made payable to the Commonwealth of Massachusetts for $90.00. Cash is not accepted. All fees are non-refundable and non-transferable. Do not staple check or money order to the application.

Attachment 2: Proof of Graduation from a Dental School - Provide an official transcript or letter from your dental school including date of graduation and degree conferred, and translated into English, if necessary. Photocopies will not be accepted. Diplomas will not be accepted.

Attachment 3: English Language Proficiency - If your dental degree is from a school where instruction (written or oral) was in a language other than English, documentation of a minimum score on the TOEFL or the academic format IELTS must be attached.

Test of English as a Foreign Language (TOEFL)
90 (internet-based) **OR 577** (paper-based)
OR
Academic Format International English Language Testing System (IELTS) 7.0

Attachment 4: Physician's Statement - Signed statement on physician's stationery certifying that the candidate has been examined within 6 months prior to the date of application and is deemed fit to practice dentistry.

Attachment 5: Documentation of Current CPR/AED for the Professional Rescuer or Current BLS Certification

Attachment 6: Massachusetts Dental Ethics and Jurisprudence Exam—Answer sheet only.

IF APPLICABLE

Attachment 7: Letters of Standing Verification of Professional Licensure from each state or jurisdiction in which you hold or have ever held a license must be included in the application. The letter of verification of licensure must include the current status of the license, license number, the official seal of the jurisdiction's licensing Board, and any disciplinary actions taken. A photocopy of a license is not acceptable.

Attachment 8: Practice History - If you have ever practiced dentistry in another jurisdiction or state, please include an up-to-date resume or practice history, including employers' contact information and dates of employment.

Attachment 9: National Practitioner Data Bank Self-Query Report (If you have ever held a professional healthcare license in the United States) To request a self-query report, please contact the Data Bank at 1-800-767-6732 or www.npdb-hipdb.hrsa.gov. The Data Bank will mail the report to you. Only an original report from NPDB will be accepted for this application.

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INITIAL (FIRST-TIME) FULL-TIME FACULTY LIMITED LICENSE APPLICATION INSTRUCTIONS

(See 234 CMR 1.05 Effective August 20, 2010)

A full- time Faculty Limited License allows a full-time faculty member to perform all the duties of a dentist but only in a specifically-named hospital, school, public clinic, or prison Private practice is not permitted at any time Full-Time Faculty Limited Licenses are valid for exactly one year from date of issue and may be re-applied for annually The Board may issue a Full- Time Faculty Limited License provided it receives the following documentation:

- An accurate, complete, and signed application including CORI report.
- Payment of a nonrefundable, nontransferable licensing fee.
- Proof satisfactory to the Board that the applicant has received a diploma in dentistry Graduates of non-CODA or foreign dental schools shall submit an original transcript, with college seal that indicates the date of issuance of a dental diploma from a reputable dental college. If the transcript is not in English, the applicant shall provide a certified translated copy of the original dental college transcript demonstrating the applicant received a dental degree from a reputable dental college.
- A full-time member of faculty shall submit an original letter with the college seal that confirms the applicant's status and dates of appointment as a full-time faculty member. The application for licensure shall also include the printed name, signature and license number of the applicant's supervising dentist, who shall hold a valid license issued by the Board pursuant to M. G. L. c. 112, § 45 and be in good standing with the Board.
- Documentation demonstrating current certification in American Red Cross Cardiopulmonary Resuscitation Automated External Defibrillation for the Professional Rescuer (CPR/AED) or current certification in the American Heart Association Basic Life Support for Healthcare Providers (BLS).
- If the applicant has graduated from a dental school where the language of written or oral instruction (including textbooks) or both, is in a language other than English, the applicant shall submit documentation satisfactory to the Board that the applicant has achieved a minimum score, as specified by the Board, on a Board-designated test of English proficiency.
- A physician's statement that is the result of an examination, conducted within six months of the date of application, attesting to the health of the applicant and reporting impairments which may affect the applicant's ability to practice dentistry.
- If applicable, certified letters of standing from all jurisdictions in which the applicant has ever been issued a license to practice dentistry attesting to the standing of his/her license, including report of any past or pending disciplinary action, or any pending complaints against the applicant.
- A practice history, if applicable.

- An original report from the National Practitioner Data Bank (NPDB) Self-query.
- A statement disclosing any disciplinary action, civil and/or criminal action taken against the applicant at any time prior to the date of application, with supporting documentation as may be required by the Board.
- Successful completion of the Massachusetts Dental Ethics and Jurisprudence Examination. Email the Board at dentistry.admin@state.ma.us to request a copy of the exam.
- Attach a passport-size photograph in color (2x2) to application where indicated. See http://travel.state.gov/passport/guide/composition/composition_87.html
- An affidavit, signed under pains and penalties of perjury, and witnessed by a Notary Public.

PLEASE NOTE:

- Incomplete applications will delay license processing.
- Please retain a copy of all application materials for your records.
- Upon board approval, a certificate and a license number will be issued in your name and sent to your supervising dentist. Confirmation of your license number will be available under "Online Services/Check a License" on our website **www.mass.gov/dph/boards/dn** as soon as the Board approves the license.
- To contact potential employers or dental educational programs or educational opportunities

Hospitals	**www.mahospitalcareers.com**
Community Health Centers	www.massleague.org
Massachusetts Department of Corrections	www.mass.gov/doc
Harvard University School of Dental Medicine	www.hsdm.harvard.edu
Boston University Goldman School of Dental Medicine	www.bu.edu/dental/
Tufts University School of Dental Medicine	www.tufts.edu/dental

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BOARD USE ONLY

Receipt #

Fee :

Jurisprudence: Pass Fail

APPLICATION
INITIAL (FIRST-TIME) FULL-TIME FACULTY LICENSE

1. APPLICANT NAME:
(Last) (First) (Middle)

2. MAIDEN NAME/OTHER NAME:

3. ADDRESS OF RECORD:
(No.) (Street) (Apt #) (City or Town) (State or Country) (Zip Code)

Note: The address of record may be home or business and is, by law, public information

4. MOST RECENT PREVIOUS ADDRESS

5. TELEPHONE NUMBER AND EMAIL ADDRESS: Day: Cell:

Email Address:

6. EYE COLOR:
Date of Birth (mm dd yyyy) Place of Birth (city state country)

HEIGHT: Feet Inches WEIGHT: Lbs MOTHER'S MAIDEN NAME:

7. SOCIAL SECURITY NUMBER (SSN) **(disclosure is mandatory):**
Pursuant to M.G.L. c. 62C, s. 47A, the Division of Health Professions Licensure is required to obtain your SSN and forward it to the Massachusetts Department of Revenue. The Department of Revenue will use your SSN to ascertain whether or not you are in compliance with Massachusetts tax laws (M.G.L. c. 62C, s. 47A) and child support laws (M.G.L. c. 119A, s.16).

EDUCATION

8. GRADUATE OF:

Name of Dental School

Street City State Province Postal Code Country

9. DATE DENTAL DEGREE CONFERRED DATE MM DD YYYY DEGREE

ALL APPLICANTS MUST ATTACH:

AN OFFICIAL TRANSCRIPT OF ORIGINAL DEGREE OR LETTER FROM YOUR DENTAL SCHOOL INCLUDING DATE (MONTH, DAY, YEAR) OF GRADUATION AND DEGREE CONFERRED; AND,

IF APPLICABLE, AN ACADEMIC CREDENTIALS EVALUATION IN ENGLISH.

VERIFICATION OF OTHER LICENSES/BOARD REGISTRATIONS

10. LIST BELOW ALL PROFESSIONAL LICENSES OR REGISTRATIONS INCLUDING PROFESSIONS OTHER THAN DENTISTRY WHETHER OR NOT YOU HAVE PRACTICED UNDER THAT LICENSE OR REGISTRATION.

NOTE: Applicants must obtain official verification of each professional license or registration from each state or jurisdiction and submit it with this application.

☐ **I DO NOT CURRENTLY HOLD AND HAVE NEVER HELD A PROFESSIONAL LICENSE OR CERTIFICATION IN ANY STATE OR JURISDICTION**

☐ **I CURRENTLY HOLD AND HAVE A PROFESSIONAL LICENSE OR REGISTRATION AS FOLLOWS:**

Issuing Jurisdiction Profession License Certification Number

PRACTICE LOCATION(S)

12. (A). NAME OF SPONSORING INSTITUTION/CLINIC

ADDRESS

PHONE #

PRACTICE TO BEGIN:

MM DD YYYY

SUPERVISING DENTIST NAME

MASSACHUSETTS DENTAL LICENSE #DN

I CERTIFY, UNDER PAINS AND PENALTIES OF PERJURY, THAT THE INFORMATION I HAVE PROVIDED PURSUANT TO THIS APPLICATION FOR LICENSURE IS TRUTHFUL AND ACCURATE.

SUPERVISING DENTIST SIGNATURE

12. (B). OTHER AFFILIATED PRACTICE LOCATION

ADDRESS

PHONE #

PRACTICE TO BEGIN:

MM DD YYYY

SUPERVISING DENTIST NAME

MASSACHUSETTS DENTAL LICENSE #DN

I CERTIFY, UNDER PAINS AND PENALTIES OF PERJURY, THAT THE INFORMATION I HAVE PROVIDED PURSUANT TO THIS APPLICATION FOR LICENSURE IS TRUTHFUL AND ACCURATE.

SUPERVISING DENTIST SIGNATURE

12. (C). OTHER AFFILIATED PRACTICE LOCATION

ADDRESS

PHONE #

PRACTICE TO BEGIN:

MM DD YYYY

SUPERVISING DENTIST NAME

MASSACHUSETTS DENTAL LICENSE #DN

I CERTIFY, UNDER PAINS AND PENALTIES OF PERJURY, THAT THE INFORMATION I HAVE PROVIDED PURSUANT TO THIS APPLICATION FOR LICENSURE IS TRUTHFUL AND ACCURATE.

SUPERVISING DENTIST SIGNATURE

ATTESTATION OF COMPLIANCE WITH 234 CMR 4.05(5) EDUCATION REQUIREMENTS

13. CHECK THE APPLICABLE BOX BELOW, THEN SIGN TO INDICATE YOUR CERTIFICATION OF THE CHECKED STATEMENT. THE SIGNATURE OF THE SUPERVISING DENTIST IS ALSO REQUIRED ON THIS PAGE.

☐ I certify, under pains and penalties of perjury that I have completed or shall complete, within one year of the date of initial licensure, all of the following continuing education units (CEU's):

A minimum of 3 CEU's in *CDC Guidelines*;
A minimum of 3 CEU's in OSHA Standards at 29 CFR;
A minimum of 6 CEU's in treatment planning and diagnosis;
A minimum of 3 CEU's in record-keeping;
A minimum of 2 CEU's in risk management; and
A minimum of 3 CEU's in pharmacology with emphasis on prescription writing;

OR

☐ I certify, under pains and penalties of perjury that I am enrolled in a CODA-accredited dental school academic program that includes <u>all</u> areas of study listed above.

NAME OF SCHOOL GRADUATION YEAR

REQUIRED SIGNATURES:

SIGNATURE OF APPLICANT

SIGNATURE OF SUPERVISING DENTIST AS WITNESS TO APPLICANT'S ATTESTATION

GOOD MORAL CHARACTER QUESTIONS

IF YOU ANSWER "YES" TO ANY OF THE FOLLOWING QUESTIONS PLEASE ATTACH A SEPARATE SHEET EXPLAINING THE CIRCUMSTANCES. ALSO PROVIDE ALL RELEVANT CERTIFIED DOCUMENTATION (POLICE REPORTS, COURT RECORDS, DISCIPLINARY ACTION REPORTS, ETC.) INCLUDING FINAL DISPOSITION OF THE MATTER.

14. Have you ever applied for and been denied a professional license in the United States or any country or foreign jurisdiction?

Yes [ ] No [ ]

15. Has any licensing or certification board, government authority, hospital or health care facility or professional medical association located in the United States or any country or foreign jurisdiction taken any disciplinary action against you?

Yes [ ] No [ ]

16. Are you the subject of pending disciplinary actions by any licensing or certification board, government authority, hospital or health care facility or professional medical association located in the United States or any country or foreign jurisdiction?

Yes [ ] No [ ]

17. Have you ever voluntarily surrendered any professional license or board certification in the United States or any country or foreign jurisdiction?

Yes [ ] No [ ]

18. Have you ever been arrested, charged, arraigned, indicted, prosecuted, convicted or been the subject of any criminal investigation or any court proceeding in relation to any criminal violation? Do not report minor violations for which a fine of $100 or less was imposed.

Yes [ ] No [ ]

RELEASE

I hereby authorize all hospitals, institutions, credentialing agencies, organizations, personal physicians, employers (past and present), business and dental associates (past and present), and all government agencies and entities (local, state, federal, or foreign) to release to the Board of Registration in Dentistry any information, files or records requested by the Board in connection with the processing of my application. I further authorize the Board of Registration in Dentistry to release information contained in this application in association with its processing.

AFFIDAVIT OF APPLICANT

To the best of my knowledge and belief, I have filed all state tax returns and paid all state taxes required by state law and do not owe child support. I am aware of my professional obligations under M.G.L. c. 119 s. 51A, the reporting of suspected child abuse.

I understand that the Board is certified by the Massachusetts Criminal History Systems Board for access to Criminal Offender Record Information (CORI), including conviction and pending criminal case data. As an applicant for a license to practice as a full-time faculty limited licensed dentist I understand that a CORI check may be conducted by the Board for conviction and pending criminal case information only and that the CORI results will not necessarily disqualify me.

I understand that I am responsible for reading and understanding the laws and regulations governing practice as a full-time faculty limited licensed dentist in Massachusetts and I hereby agree to comply with such laws and regulations.

I understand that this application for licensure shall be deemed no longer valid if requirements for licensure as a full-time faculty limited licensed dentist are not met within one (1) year from the date of Board receipt. I also understand that fees are non-refundable and non-transferable.

I certify, under the pains and penalties of perjury, that the information I have provided pursuant to this application for licensure is truthful and accurate. I understand that any failure to provide truthful and accurate information in connection with this application for licensure may be grounds for the Board of Registration in Dentistry to deny issuance of a license; to suspend or revoke a license issued to me; and to deny renewal of a license issued to me, all in accordance with Massachusetts law.

To be completed, signed and witnessed by the applicant and a Notary Public.

APPLICANT SIGNATURE DATE

PRINT NAME

Attach a recent color 2"x 2" passport-sized Photo

NOTARY PUBLIC NAME:

NOTARY PUBLIC COMMISSION EXPIRES: [Seal or Stamp]

SUBMIT A NONREFUNDABLE AND NONTRANSFERABLE FEE FOR $90 (CHECK OR MONEY ORDER) PAYABLE TO THE COMMONWEALTH OF MASSACHUSETTS

The Commonwealth of Massachusetts
Division of Health Professions Licensure
Board of Registration in Dentistry
239 Causeway Street, 5th Floor, Suite 500
Boston, MA 02114
(617) 973-0971
www.mass.gov/dph/boards/dn

CRIMINAL OFFENDER RECORD INFORMATION (CORI) ACKNOWLEDGEMENT FORM

TO BE USED BY ORGANIZATIONS CONDUCTING CORI CHECKS FOR EMPLOYMENT, VOLUNTEER, SUBCONTRACTOR, LICENSING, AND HOUSING PURPOSES.

The Board of Registration in Dentistry is registered under the provisions of M.G.L. c. 6, § 172 to receive CORI for the purpose of screening current and otherwise qualified license applicants and current licensees.

As a prospective or current license applicant or current licensee, I understand that a CORI check will be submitted for my personal information to the Department of Criminal Justice Information Systems (DCJIS). I hereby acknowledge and provide permission to the Board of Registration in Dentistry to submit a CORI check for my information to the DCJIS. This authorization is valid for one year from the date of my signature. I may withdraw this authorization at any time by providing written notice of my intent to withdraw consent to a CORI check.

FOR EMPLOYMENT, VOLUNTEER, AND LICENSING PURPOSES ONLY

The Board of Registration in Dentistry may conduct subsequent CORI checks within one year of the date this Form was signed by me provided, however, that Board of Registration in Dentistry must first provide me with written notice of this check.

By signing below, I provide my consent to a CORI check and acknowledge that the information provided on Page 2 of this Acknowledgement Form is true and accurate.

SIGNATURE

DATE

NOTE: The Board of Registration in Dentistry cannot accept this form unless it is either (1) signed in person at the Board's offices in the presence of a DHPL employee who has verified the applicant's identity through acceptable identification, or (2) signed in the presence of a notary public who has likewise verified identity and then mailed or hand-delivered to the Board's offices at the address set forth above.

CRIMINAL OFFENDER RECORD INFORMATION (CORI) ACKNOWLEDGEMENT FORM

SUBJECT INFORMATION: (An asterisk (*) denotes a required field)

*Last Name *First Name Middle Name Suffix

Maiden Name (or other name(s) by which you have been known)

*Date of Birth Place of Birth

*Last Six Digits of Your Social Security Number: -

Sex: Height: ft. in. Eye Color: Race:

Driver's License or ID Number: State of Issue:

Mother's Full Name (Mother's Maiden Name) Father's Full Name

Current and Former Addresses:

Street Number & Name City Town State Zip

Street Number & Name City Town State Zip

The above information was verified by reviewing the following form(s) of government-issued identification:

VERIFIED BY: ON

Name of Verifying DHPL Employee (Please Print) Date

Signature of Verifying DHPL Employee OR Notary Public

NOTARY NAME:

COMMISSION EXPIRES [Seal or stamp]

ATTACHMENT CHECKLIST

Your application cannot be processed without all of the following:

Attachment 1: Licensing Fee - Personal or business check or money order made payable to the Commonwealth of Massachusetts for $90.00. Cash is not accepted. All fees are nonrefundable and nontransferable. Please do not staple check or money order to the application.

Attachment 2: Proof of Graduation from a Dental School - Provide an official transcript or letter from your dental school including date of graduation and degree conferred, and translated into English, if necessary. Photocopies will not be accepted. Diplomas will not be accepted.

Attachment 3: English Language Proficiency - If your dental degree is from a school where instruction (written or oral) was in a language other than English, documentation of a minimum score on the TOEFL or the academic format IELTS must be attached.

Test of English as a Foreign Language (TOEFL)
90 (internet-based) **OR** 577 (paper-based)
OR
Academic Format International English Language Testing System (IELTS) 7.0

Attachment 4: Physician's Statement - Signed statement on physician's stationery certifying that the candidate has been examined within 6 months prior to the date of application and is deemed fit to practice dentistry.

Attachment 5: Documentation of Current CPR/AED for the Professional Rescuer or Current BLS Certification

Attachment 6: Massachusetts Dental Ethics and Jurisprudence Exam Answer sheet only.

Attachment 7: Confirmation of Full-Time Faculty Appointment - An original letter signed by a school official on institutional stationery, including dates of faculty appointment.

IF APPLICABLE

Attachment 8: Letters of Standing Verification of Professional Licensure from each state or jurisdiction in which you hold or have ever held a license must be included in the application. The letter of verification of licensure must include the current status of the license, license number, the official seal of the jurisdiction's licensing Board, and any disciplinary actions taken. A photocopy of a license is not acceptable

Attachment 9: Practice History - If you have ever practiced dentistry in another jurisdiction or state, please include an up-to-date resume or practice history, including employers' contact information and dates of employment.

Attachment 10: National Practitioner Data Bank Self-Query Report (If you have ever held a professional healthcare license in the United States) To request a self-query report, please contact the Data Bank at 1-800-767-6732 or www.npdb-hipdb.hrsa.gov. The Data Bank will mail the report to you. Only an original report from NPDB will be accepted for this application.