BOARD OF DENTISTRY

HEALTH ACCESS DENTAL LICENSE APPLICATION

Definition from Chapter 466.003(14), F.S.
"Health access setting" means a program or an institution of the Department of Children and Family Services, the Department of Health, the Department of Juvenile Justice, a nonprofit community health center, a Head Start center, a federally qualified health center or look-alike as defined by federal law, a school-based prevention program, a clinic operated by an accredited college of dentistry, or an accredited dental hygiene program in this state if such community service program or institution immediately reports 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 setting.

REQUIREMENTS FOR HEALTH ACCESS DENTAL LICENSURE:

- Has not been convicted of or pled nolo contendere to, regardless of adjudication, any felony or misdemeanor related to the practice of a health care profession;
- Submits proof of graduation from a dental school accredited by the Commission on Dental Accreditation of the American Dental Association or its successor agency;
- Submits documentation that she or he has completed, or will obtain prior to licensure, continuing education equivalent to this state's requirement for dentists licensed under s. 466.006, F.S., for the last full reporting biennium before applying for a health access dental license; (biennium begins March 1 of every even year, i.e. March 1, 2008 – February 28, 2010) See Chapter 64B5-12.013, Florida Administrative Code, for continuing education requirements.
- Submits proof of her or his successful completion of parts I and II of the National Board of Dental Examiners Examination and a state or regional clinical dental licensing examination that the board has determined effectively measures the applicant's ability to practice safely;
- Currently holds a valid, active, dental license in good standing which has not been revoked, suspended, restricted, or otherwise disciplined from another of these United States, the District of Columbia, or a United States territory;
- Has never had a license revoked from another of these United States, the District of Columbia, or a United States territory;
- Has never failed the examination specified in s. 466.006, F.S., unless the applicant was reexamined pursuant to s. 466.006, F.S., and received a license to practice dentistry in this state;
- Has not been reported to the National Practitioner Data Bank, unless the applicant successfully appealed to have his or her name removed from the data bank;

- Submits proof that he or she has been engaged in the active, clinical practice of dentistry providing direct patient care for 5 years immediately preceding the date of application, or in instances when the applicant has graduated from an accredited dental school within the preceding 5 years, submits proof of continuous clinical practice providing direct patient care since graduation; and
- Has passed an examination covering the laws and rules of the practice of dentistry in this state as described in s. 466.006(4)(a), F.S.

Applicants are encouraged to thoroughly 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 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	305.00*
TOTAL FEE	**$ 485.00**

*Licensure fee is $155 for applicants applying in the second year of the biennium. All initial licenses expire February 28 of the following even numbered year. Licensure biennium dates are March 1 – February 28 of the even years.

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 Dental 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.cebroker.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 the name change document. All documentation must be official.

SPECIAL ACCOMODATIONS

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

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

Revised 08/12

FLORIDA DEPARTMENT OF HEALTH

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	Primary 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? 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 / /

Are special accommodations necessary for the Laws and Rules Examination? Yes_____ No_____

2. 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:

- 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.

B. Have you successfully completed the National Board of Dental Examiners Dental Examination?

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

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

3. APPLICANT EXPERIENCE

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):

4. 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. Circle Yes No

- If yes, please list date, jurisdiction (state and county), offense, disposition, and all other relevant information on reverse side or an attached sheet

B. IMPORTANT NOTICE: Applicants for licensure, certification or registration and candidates for examination may be excluded from licensure, certification or registration if their felony conviction falls into certain timeframes as established in Section 456.0635(2), Florida Statutes. If you answer YES to any of the following questions, please provide a written explanation for each question including the county and state of each termination or conviction, date of each termination or conviction, and copies of supporting documentation to the address below. Supporting documentation includes court dispositions or agency orders where applicable.

1. Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under Chapter 409, F.S. (relating to social and economic assistance), Chapter 817, F.S. (relating to fraudulent practices), Chapter 893, F.S. (relating to drug abuse prevention and control) or a similar felony offense(s) in another state or jurisdiction? **(If you responded "no", skip to #2.)** Yes No

a. **If "yes" to 1,** for the felonies of the first or second degree, has it been more than 15 years from the date of the plea, sentence and completion of any subsequent probation? Yes No

b. **If "yes" to 1,** for the felonies of the third degree, has it been more than 10 years from the date of the plea, sentence and completion of any subsequent probation? (This question does not apply to felonies of the third degree under Section 893.13(6)(a), Florida Statutes). Yes No

c. **If "yes" to 1,** for the felonies of the third degree under Section 893.13(6)(a), Florida Statutes, has it been more than 5 years from the date of the plea, sentence and completion of any subsequent probation? Yes No

d. **If "yes" to 1,** have you successfully completed a drug court program that resulted in the plea for the felony offense being withdrawn or the charges dismissed? (If "yes", please provide supporting documentation). Yes No

2. Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under 21 U.S.C. ss. 801-970 (relating to controlled substances) or 42 U.S.C. ss. 1395-1396 (relating to public health, welfare, Medicare and Medicaid issues)? Yes No

a. **If "yes" to 2,** has it been more than 15 years before the date of application since the sentence and any subsequent period of probation for such conviction or plea ended? Yes No

3. Have you ever been terminated for cause from the Florida Medicaid Program pursuant to Section 409.913, Florida Statutes? **(If "No", do not answer 3a.)** Yes No

a. 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

4. Have you ever been terminated for cause, pursuant to the appeals procedures established by the state from any other state Medicaid program **(If no, do not answer 4a or 4b.)** Yes No

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

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

5. Are you currently listed on the United States Department of Health and Human Services Office of Inspector General's List of Excluded Individuals and Entities? Yes No

6. If "yes" to any of the questions 1 through 5 above, on or before July 1, 2009, were you enrolled in an educational or training program in the profession in which you are seeking licensure that was recognized by this profession's licensing board or the Department of Health? (If "yes", please provide official documentation verifying your enrollment status.) Yes No

5. APPLICANT HISTORY – PROFESSIONAL LICENSURE

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

B. Have you ever failed the Florida clinical dental examination or the ADEX dental examination? Yes No

C. Have you ever been refused a license to practice Dentistry 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 in instances where you graduated from an accredited school within the preceding 5 years, 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? Yes No

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

- If Questions 5A, 5B, 5C, 5D, 5E, 5F, 5G or 5H 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.

6. APPLICANT LICENSURE STATUS

A. Do you now hold or have you ever held a license to practice Dentistry 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 Licensure currently pending in any state or foreign country? Yes No If "YES", list ALL such state or jurisdictions below

7. WRITTEN DECLARATION

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

I understand that whoever knowingly makes a false statement in writing with the intent to mislead a public servant in the performance of his or her official duty shall be guilty of a misdemeanor of the second degree pursuant to s. 837.06, F.S.

Applicant Signature _____ Date _____

8. 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: #1, Applicant Profile Data.

CONFIDENTIAL AND EXEMPT FROM PUBLIC RECORDS DISCLOSURE

DEPARTMENT OF HEALTH
FLORIDA BOARD OF DENTISTRY
APPLICATION FOR HEALTH ACCESS DENTAL LICENSE

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 § 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.

Name: _____
Last First Middle

Social Security Number: _____

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.

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

REMINDER

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

A copy of your National Board Dental Examination scores should be sent directly from the American Dental Association 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 in the state of _____

on the _____ day of _____, 20_____, on the basis of _____

_____
(specifiy 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.