Dentistry Licensure Application

Board *of* Dentistry
P.O. Box 6330
Tallahassee, FL 32314-6330
Website: floridasdentistry.gov
Email: MQA.Dentistry@flhealth.gov
Phone: (850) 245-4474
Fax: (850) 921-5389

DH-MQA 1182, Revised 11/2024, Rules 64B5-2.014 and 64B5-2.0146, F.A.C.

Are you an active-duty member of the United States Armed Services?

Are you a veteran of the United States Armed Services?

Are you the spouse of a veteran of the United States Armed Services?

Are you the spouse of an active member of the United States Armed Services?

If you answered "Yes" to any of these questions, you may qualify for a reduction in your application fees. You can find information about the Florida Department of Health's commitment to serving members and veterans of the United States Armed Forces and their families online at http://www.flhealthsource.gov/valor.

Dentistry Licensure Application

Board of Dentistry
P.O. Box 6330
Tallahassee, FL 32314-6330
Fax: (850) 921-5389
Email: MQA.Dentistry@flhealth.gov

Do Not Write in this Space
For Revenue Receipting Only

Applicants are encouraged to review section (s.) 466.006, Florida Statutes, and Rule Chapter (ch.) 64B5-2, Florida Administrative Code (F.A.C.), prior to completing your application.

Dentistry License

Full Fee: $405.00

Reduced Fee: $255.00 *(Only for applications submitted from March 1st of an odd year to September 30th of an odd year)*

Total fee includes the following:

Application Fee	$100.00
Initial Licensure Fee **(Full)**	$300.00
Initial Licensure Fee **(Reduced)**	$150.00
Unlicensed Activity Fee	$5.00

All initial licenses expire February 28 of the next even numbered year following the date of issuance.

Fees must be paid in the form of a cashier's check or money order, made payable to the Department of Health. An applicant who is denied licensure or withdraws their application is entitled to a $305.00 (full) or $160.00 (reduced) (Initial Licensure Fee and Unlicensed Activity Fee) refund. Requests to withdraw or for a refund must be made in writing. Fees are refundable for up to three years from the date of receipt.

1. PERSONAL INFORMATION

Name: _____ **Date of Birth:** _____
Last/Surname First Middle MM/DD/YYYY

Mailing Address: (The address where mail and your license should be sent)

_____ _____ _____
Street/P.O. Box Apt. No. City

_____ _____ _____ _____
State ZIP Country Home/Cell Telephone

Physical Location: (Required if mailing address is a P.O. Box- This address will be posted on the Department of Health's website.)

_____ _____ _____
Street Suite No. City

_____ _____ _____ _____
State ZIP Country Work/Cell Telephone

EQUAL OPPORTUNITY DATA:
We are required to ask that you furnish the following information as part of your voluntary compliance with 41 CFR Part 60-3-Uniform Guidelines on Employee Selection Procedure (1978); 43 FR 38295 and 38296 (August 25, 1978). This information is gathered for statistical and reporting purposes only and does not in any way affect your candidacy for licensure.

Gender:	Male	Race:	Native Hawaiian or Pacific Islander	Hispanic or Latino	White
	Female		American Indian or Alaska Native	Black or African American	Asian
			Two or More Races		

Email Notification: To be notified of the status of your application by email, check the "Yes" box and fill in your email address on the line provided. If you choose to be notified via email you will be responsible for checking your email regularly and updating your email address with the board office.

Yes No Email Address: _____

Under Florida law, email addresses are public records. If you do not want your email address released in response to a public records request, do not provide an email address or send electronic mail to our office. Instead contact the office by phone or in writing.

2. SOCIAL SECURITY DISCLOSURE

This information is exempt from public records disclosure.

Pursuant to Title 42 United States Code § 666(a)(13), the department is required and authorized to collect Social Security numbers relating to applications for professional licensure. Additionally, section (s.) 456.013(1)(a), Florida Statutes, authorizes the collection of Social Security numbers as part of the general licensing provisions.

Last Name: _____

First Name: _____

Middle Name: _____

U.S. Social Security Number: _____

Social Security Information- * Under the Federal Privacy Act, disclosure of Social Security numbers is voluntary unless specifically required by federal statute. In this instance, Social Security numbers are mandatory pursuant to Title 42 United States Code § 653 and 654; and s. 456.013(1), 409.2577, and 409.2598, Florida Statutes. Social Security numbers are used to allow efficient screening of applicants and licensees by a Title IV-D child support agency to ensure compliance with child support obligations. Social Security numbers must also be recorded on all professional and occupational license applications and will be used for license identification pursuant to Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Welfare Reform Act. 104 Pub. L. Section 317). Clarification of the SSA process may be reviewed at www.ssa.gov or by calling 1-800-772-1213.

Name: _____

3. APPLICANT BACKGROUND

A. 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

If "Yes," list name(s) and date(s) of change(s):

_____

B. Do you hold, or have you ever held a license to practice dentistry or dental hygiene in any state, U.S. territory, or foreign country? Yes No

C. List all health-related licenses (active, inactive, or lapsed), starting with the most recent.

License Type	License #	State/Country	Original Date Issued (MM/DD/YYYY)	Expiration Date (MM/DD/YYYY)	Status of License

Submit a License Verification form to **ALL** state(s) of licensure. License verifications must be received directly from the licensing authority regardless of the status of the license. **A copy of your license will not be accepted** in lieu of official verification from the licensing agency. If the state has an online **verification including disciplinary actions,** the board office will accept the online verification.

D. Are you registered with the Drug Enforcement Administration (DEA) to prescribe controlled substances?
Yes No

If "Yes," provide your DEA number: _____

Submit all supporting documentation not included with the application to the board office at:

Board *of* Dentistry
4052 Bald Cypress Way Bin C-04
Tallahassee, FL 32399-3258

Name: _____

4. EDUCATION HISTORY

A. Did you graduate, or do you anticipate graduating, from a dental school accredited by the American Dental Association Commission on Dental Accreditation or its successor agency? Yes No

If "No," submit proof of completion of at least two consecutive academic years at a full-time supplemental general dentistry program accredited by the American Dental Association Commission on Dental Accreditation. This program **must** provide didactic and clinical education at the level of a D.D.S. or D.M.D. program accredited by the American Dental Association Commission on Dental Accreditation.

B. List all dental school(s) attended.

School Name	Address	Graduation/ Anticipated Date (MM/DD/YYYY)	Degree Awarded

All applicants must have an official transcript forwarded directly to the board office from the educational institution. Transcripts must indicate the matriculation date, graduation date, degree earned, and be embossed with the school seal. Diplomas and student copies **are not acceptable**.

C. Have you received training and hold current certification from the American Heart Association, the American Red Cross, or entity with equivalent requirements 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? Yes No

American Heart Association	Certification #:
American Red Cross	Issue Date (MM/DD/YYYY):
Other: _____	Expiration Date (MM/DD/YYYY):

5. EXAMINATION HISTORY

A. Have you successfully completed the National Board of Dental Examiners Examination? Yes No

B. Did you take the exam under a name other than the one provided in the **"Personal Information"** section on page 3? Yes No

If "Yes," provide the name: _____

All applicants must have National Board of Dental Examiners Examination scores sent directly to the board office from The Joint Commission on National Dental Examination (JCNDE). The JCNDE may be reached at (800) 232-1694.

C. Have you successfully completed the Florida Laws and Rules examination provided by the Commission on Dental Competency Assessment (CDCA)? Yes No

If "No," visit www.cdcaexams.org to register.

D. Have you successfully completed the ADEX Dental Licensing Examination either in Florida, **or** in a jurisdiction other than Florida after October 1, 2011? Yes No

E. ADEX Exam Date: _____ (MM/DD/YYYY) ADEX Exam Location: _____ (City) _____ (State)

Applicants who completed the ADEX Exam in a jurisdiction other than Florida may have additional requirements. Refer to s. 466.006, Florida Statutes, and Rule 64B5-2.0150, F.A.C.

Name: _____

This information is exempt from public records disclosure.

6. HEALTH HISTORY

Physical and Mental Health Disorders Impacting Ability to Practice

A. During the last two years, have you been treated for or had a recurrence of a diagnosed physical or mental disorder that impaired or would impair your ability to practice? Yes No

B. In the last two years, have you been admitted or referred to a hospital, facility or impaired practitioner program for treatment of a diagnosed mental or physical disorder that impaired your ability to practice? Yes No

Substance-Related Disorders Impacting Ability to Practice

C. During the last five years, have you been treated for or had a recurrence of a diagnosed substance-related (alcohol or drug) disorder that impaired or would impair your ability to practice? Yes No

D. During the last five years, were you admitted or directed into a program for the treatment of a diagnosed substance-related (alcohol or drug) disorder or, if you were previously in such a program, did you suffer a relapse? Yes No

E. During the last five years, have you been enrolled in, required to enter, or participated in any substance-related (alcohol or drug) recovery program or impaired practitioner program for treatment of drug or alcohol abuse? Yes No

If a "Yes" response was provided to any of the questions in this section, provide the following documents directly to the board office:

A letter from a Licensed Health Care Practitioner, who is qualified by skill and training to address the condition identified, which explains the impact the condition may have on the ability to practice the profession with reasonable skill and safety. The letter must specify that the applicant is safe to practice the profession without restrictions or specifically indicate the restrictions that are necessary. Documentation provided must be dated within one year of the application date.

A written self-explanation, identifying the medical condition(s) or occurrence(s); and current status

7. DISCIPLINE HISTORY

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 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 alleged negligence, malpractice, or lack of professional competence? Yes No

E. Do you have a pending complaint in any jurisdiction against your professional conduct or competence as a dentist or dental hygienist? Yes No

If you responded "Yes" to any of the questions in this section, complete the following:

Name of Agency	State	Action Date (MM/DD/YYYY)	Final Action	Under Appeal?
				Y N
				Y N
				Y N
				Y N

If you responded "Yes" to any of the questions in this section, you must provide the following:

A written self-explanation, describing in detail the circumstances surrounding the disciplinary action.

A copy of the **Administrative Complaint** and **Final Order**.

8. CRIMINAL HISTORY

*For the question below, you **must include** all misdemeanors and felonies, even if adjudication was withheld. Reckless driving, driving while license suspended or revoked (DWLSR), driving under the influence (DUI) or driving while impaired (DWI) are **not** minor traffic offenses for purposes of this question.*

*Pursuant to s. 943.0585(6)(b), Florida Statutes, and s. 943.059(6)(b), Florida Statutes, an applicant seeking to be licensed by the Department of Health **must disclose** expunged and sealed criminal history records.*

Have you ever been convicted of, or entered a plea of guilty, nolo contendere, or no contest to any crime in any jurisdiction other than a minor traffic offense? Yes No

If you responded "Yes," complete the following:

Offense	Jurisdiction	Date (MM/DD/YYYY)	Final Disposition	Under Appeal?
				Y N
				Y N
				Y N

If you responded "Yes" in this section, you must provide the following:

A written self-explanation, describing in detail the circumstances surrounding each offense; including dates, city and state, charges and final results.

Final Dispositions and **Arrest Records** for all offenses. The Clerk of the Court in the arresting jurisdiction will provide you with these documents. Unavailability of these documents must come in the form of a letter from the Clerk of the Court.

Completion of Sentence Documents. You may obtain documents from the Department of Corrections. The report must include the start date, end date, and that the conditions were met.

Name: _____

9. CRIMINAL AND MEDICAID/MEDICARE FRAUD QUESTIONS

IMPORTANT NOTICE: Applicants for licensure, certification, or registration and candidates for examination may be excluded from licensure, certification, or registration if their felony convictions fall into certain timeframes as established in s. 456.0635(2), Florida Statutes.

1. Have you been convicted of, or entered a plea of guilty or nolo contendere, regardless of adjudication, to a felony under chapter (ch.) 409, Florida Statutes (relating to social and economic assistance), ch. 817, Florida Statutes (relating to fraudulent practices), ch. 893, Florida Statutes (relating to drug abuse prevention and control), or a similar felony offense(s) in another state or jurisdiction? Yes No

   If you responded "No" to the question above, skip to question 2.

   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 subsequent probation (this question does not apply to felonies of the third degree under s. 893.13(6)(a), Florida Statutes)? Yes No

   c. If "Yes" to 1, for the felonies of the third degree under s. 893.13(6)(a), Florida Statutes, has it been more than five 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," provide supporting documentation)? Yes No

2. Have you been convicted of, or entered a plea of guilty or nolo contendere, regardless of adjudication, to 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

   If you responded "No" to the question above, skip to question 3.

   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 s. 409.913, Florida Statutes? Yes No

   If you responded "No" to the question above, skip to question 4.

   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? Yes No

   If you responded "No" to the question above, skip to question 5.

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

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

Name: _____

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

   a. If you responded "Yes" to the question above, are you listed because you defaulted or are delinquent on a student loan? Yes No

   b. If you responded "Yes" to question 5.a., is the student loan default or delinquency the only reason you are listed on the LEIE? Yes No

If you responded "Yes" to any of the questions in this section, you must provide the following:

A written self-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.

Supporting documentation including court dispositions or agency orders where applicable.

Documents in sections 6, 7, 8, and 9 must be mailed to:

Board *of* Dentistry
4052 Bald Cypress Way Bin C-04
Tallahassee, FL 32399-3258

10. OATH/VERIFICATION OF DOCUMENT

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.

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.

Under penalties of perjury, I declare that I have read the foregoing Dental Licensure Application and that the facts stated in it are true.

Applicant Signature _____ Date _____
MM/DD/YYYY

Online verifications submitted by the applicant are acceptable if they are current and show disciplinary history status. Complete verifications must be mailed directly from the licensing agency to:

Board *of* Dentistry
4052 Bald Cypress Way Bin C-04
Tallahassee, FL 32399-3258

Board *of* Dentistry License Verification Request

Part I: To be completed by applicant (Florida requires verification of all your current and previously held licenses.)

Name: _____

Address: _____

Name original license was issued under: _____

License Number: _____ State: _____

I hereby authorize release of any information regarding my licensure status to the Florida Board of Dentistry.

Applicant Signature: _____ Date: _____
MM/DD/YYYY

Part II: To be completed by state licensing agency

All verifications must be in English and include the following criteria:

* Typed on an official state form or letterhead
* Include an official board seal
* Signature and title of state board official

The following information must be included in all verifications:

* Licensee name
* License number
* State or jurisdiction of licensure
* Licensure status
* Is license in good standing?
* Date of issuance/expiration
* Licensure method (examination or reciprocity/endorsement)
* Has this license ever been encumbered (denied, revoked, suspended, surrendered, limited, placed on probation)?
* If this license has ever been encumbered, please provide certified copies of documentation regarding the action with the completed license verification.

Board *of* Dentistry
Financial Responsibility

This form is required for all applicants.

Name: _____

The Financial Responsibility options are divided into two categories: coverage and exemptions. **Choose only ONE** option that best describes your situation, unless you choose **option 3** in the **"Financial Responsibility Coverage"** section. If you provided financial responsibility information to a hospital or elsewhere, be consistent when choosing.

Be advised, failing to choose an option or choosing more than one option will make this form invalid and will delay your licensure. Department staff is unable to advise you on which option to choose. If you have questions regarding an option, consult your personal legal counsel, insurance company or financial institution for advice.

FINANCIAL RESPONSIBILITY COVERAGE

1. I have obtained and will maintain professional liability coverage in an amount of not less than $100,000, with a minimum annual aggregate of not less than $300,000, from an authorized insurer as defined under s. 624.09, Florida Statutes, from a surplus lines insurer as defined under s. 626.914(2), Florida Statutes, from a risk retention group as defined under s. 627.942, Florida Statutes, from the Joint Underwriting Association established under s. 627.351(4), Florida Statutes, or through a plan of self-insurance as provided in s. 627.357, Florida Statutes.

2. I have obtained and will maintain an unexpired irrevocable letter of credit as defined in ch. 675, Florida Statutes, in an amount no less than $100,000 per claim, with a minimum aggregate availability of credit not less than $300,000.

3. I am exempt from financial responsibility coverage ***(If you choose this option you must choose one option from the exemption category below.)***

EXEMPTION CATEGORIES OF FINANCIAL RESPONSIBILITY COVERAGE

1. I practice exclusively as an officer, employee, or agent of the federal government, or of the state or its agencies or subdivisions.

2. I practice only in conjunction with my teaching duties at an accredited school or in its main teaching hospitals.

3. I have no malpractice exposure because I do not practice in the state of Florida.

Section 456.067, Florida Statutes: Penalty for giving false information - In addition to, or in lieu of, any other discipline imposed pursuant to s. 456.072, Florida Statutes, the act of knowingly giving false information in the course of applying for or obtaining a license for the department, or any board thereunder, with intent to mislead a public servant in the performance of his or her duties, or the act of attempting to obtain or obtaining a license from the department, or any board thereunder, to practice a profession by knowingly misleading statements or knowing misrepresentations constitutes a felony of the third degree, punishable in s. 775.082, s. 775.083, or s. 775.08, Florida Statutes.

Applicant Signature: _____ Date: _____
MM/DD/YYYY

Board *of* Dentistry
4052 Bald Cypress Way Bin C-04
Tallahassee, FL 32399-3258

Complete verifications must be mailed directly from the verifying agency to:

Board *of* Dentistry
4052 Bald Cypress Way Bin C-04
Tallahassee, FL 32399-3258

Board *of* Dentistry Full-Time Practice Verification

Who needs to use this form?

Applicants who have passed the ADEX exam over 365 days prior to the date of their application and have practiced dentistry under a dental license issued by another U.S. state or territory **OR** during residency at an accredited dental residency program.

Applicants DO NOT need to complete this form *if they have passed the ADEX examination within 365 days prior to the application date.*

Part I: To be completed by applicant (Complete this section and submit a copy to each place where you participated in full-time practice.)

Name: _____

Name of residency program or place of employment:

_____

Address of residency program or place of employment:

_____

City: _____ State: _____ ZIP: _____

I hereby authorize release of any information regarding my employment status with your facility to the Florida Board of Dentistry.

Applicant Signature: _____ Date: _____
MM/DD/YYYY

_____

Part II: To be completed by employer- All verifications must be in English and submitted directly from the agency, employer, or office manager, if self-employed. All verifications must include the following:

* Typed on official agency letterhead with an original signature
* Applicant name
* License number (if applicable)
* Supervising dentist information (if applicable)
* Position title while employed
* Place of employment
* Address of employer (including mailing address, city, state, ZIP, country)
* Employer's telephone number (including area code)
* Length of employment, including start and end dates
* Hours worked per week
* Signature of verifying agent and date completed