MINNESOTA
BOARD OF DENTISTRY

Minnesota Board of Dentistry
2829 University Avenue SE, Suite 450
Minneapolis, MN 55414
Office: (612) 617-2250
MN Relay Service: (800) 627-3529
www.mn.gov/boards/dentistry

Please read the following information carefully before beginning your application for licensure.

General

Applications

- Print single-sided and do not staple any documents in your application.
- Attach additional sheets of paper as needed. Added sheets should specifically reference the application.
- If you send documentation separately from your application, place a post-it note on the first page of your application indicating that the required documentation is "on file at the Board".
- Once received by the Board, all applications go through a two-person review. If the CBC Unit has delivered your criminal background check results to the Board, the application is added to the queue to be processed. Applications in the queue are processed in the order in which they were date-stamped. If after the two-person review the criminal background check results have not been received, the application will be stored until the criminal background check is brought to the Board. Incomplete applications will be returned to the applicant. **This is the information you will receive if you call to ask about the status of your application.**

Criminal background check

- Applications for licensure are not processed until the applicant's criminal background check results have been delivered to the Board of Dentistry.

Notarizing documents

- To locate notary publics in Minnesota, utilize the Secretary of State's online directory. If you are not in Minnesota, refer to the governing body that regulates notary publics in your jurisdiction.
- Copies of documents requiring a notary stamp must be both **notarized and certified**. This means that the notary must 1) stamp the document with their notary stamp **and** 2) write "true copy of the original", or something to that effect.
- Have the notary notarize the front of the document itself; do not allow them to attach separate pages. Banks, which often do not certify documents, sometimes attach separate sheets of paper.

Background

- Email addresses are required for future correspondences.
- If you have legally changed your name, your application also requires a copy of the legal document that changed your name. The copy does not need to be notarized and certified.

Disclosure Questions

- If you have had a criminal conviction, please attach:
  - A personal statement detailing the events leading up to and following the conviction,
  - A copy of the court sentencing order from the designated county clerk or courthouse, and
  - A copy of the arresting officer's report, if available.

Affidavit of Applicant

- All applicants must complete the Affidavit of Applicant.
- Signatures on the Affidavit of Applicant must be original. Copies are not accepted.

Minnesota Government Data Practice Act Notice

This notice is given pursuant to Minnesota Statutes §13.04, subdivision 2, and §13.41, subdivision 2. Licensure in Minnesota requires all information requested in this application. The required documentation will determine if you meet statutory and rule prerequisites for licensure in Minnesota. Omissions or inaccuracies may lead to the rejection of your application. Except for your name and address, the contents of your application are private. Once you are licensed, that information becomes public. "Private" is defined by law as information accessible only to 1) you, 2) Board of Dentistry staff, 3) individuals designated by you, 4) individuals required to verify the application contents, and 5) the Board's legal staff. If your application becomes contested and results in litigation or a case hearing, the application materials may become available to the Minnesota Office of Administrative Hearings, designated courts, and individuals associated with any proceedings. The information will then become public.

Americans with Disabilities Act

The Minnesota Board of Dentistry complies with the Americans with Disabilities Act (ADA). The ADA asserts that qualified individuals with disabilities cannot be excluded from participating in programs, services, or activities offered by the Board of Dentistry. For more information, contact the Board of Dentistry.

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_____ **App. #**

_____ **Lic. #**

_____ **Issued**

Licensure by Credentials to Practice Dentistry

Non-refundable Fee: $926.25 (Application fee: $725, Background check fee: $33.25, Initial fee: $168)

*****PLEASE TYPE OR PRINT IN INK*****

1. BACKGROUND

A. _____
First name | Middle name | Last name | Today's date

B. _____
Mailing Address | City, state, zip code

C. _____
Telephone (including area code) | Email address (required)

D. _____
Primary practice address (required if employed) | City, state, zip code

E. _____
Practice telephone (including area code) | Practice email address

F. ☐ M ☐ F ☐ X
Gender | Birthdate (XX/XX/XXXX) | Social Security Number (XXX-XX-XXXX)

G. _____
Other names previously used and reason for name change

2. DENTAL EDUCATION

Send proof of education to the Board: have your school email e-transcript to dental.board@state.mn.us **(or)** have your school mail original/ official transcripts to the Board **(or)** include a **correctly notarized and certified copy of your diploma** (see instructions on 1st page).

A. _____ ☐ DDS ☐ DMD ☐ Other: _____
Dental school or program | Degree

B. _____
City, state | Date of graduation

C. _____
Other college or university education (include dates and degree earned)

3. EXAMINATIONS

Include originals or copies of your exam results with your application. Contact the ADA and your regional clinical exam agency's office to ensure that the Board can view your exam results in their online portal. Exams may not be more than 5 years old. **List only the final date of testing below.**

A. Minnesota Jurisprudence Exam _____
Date completed (XX/XX/XXXX)

B. Clinical Exam _____
Date completed (XX/XX/XXXX)

Select exam taken: ☐ WREB ☐ SRTA ☐ NDEB ☐ CRDTS ☐ ADEX ☐ Other: _____

C. National Board Exam

_____
Date completed (XX/XX/XXXX)

Dentpin: _____

D. Please provide the names and dates of any failed **CLINICAL** exams.

_____

_____

4. PROFESSIONAL BACKGROUND

A. Have you ever been licensed as a dental professional outside of the State of Minnesota?
Select one: ☐ No ☐ Yes

If you selected no, you do not need to complete 4B and 4C. Continue to number 5.
If you selected yes, you must complete 4B and 4C. Once completed, continue to number 5.

B. List each state and or country in which you are or have been license as a dental professional.

_____

_____

C. License Verification

You must include a license verification from each jurisdiction listed in 4B. If the licensing authority has an online portal, you may print your license verification and include it in your application. Licensing authorities may also send original license verifications directly to the Board of Dentistry. License verifications must include 1) your name, 2) your license number, 3) the date your license was issued, 4) your license status, and 5) notice of any disciplinary or corrective actions against your license. Indicate below how the Board will receive each license verification listed in 4B.

☐ I printed my license verification and included it in my application.
☐ The licensing authority will email my license verification directly to the dental.board@state.mn.us.
☐ The licensing authority will send an original copy of my license verification to the MN Board of Dentistry.
☐ I have included an original license verification in my application.

D. Employment History

Professional (**required**: active practice for at least 2,000 hours in the past 36 months)

_____
Name of practice | Practice address

_____
Your duties | Supervisor's name

_____
Dates of employment and hours worked | Reason for leaving

Other (since graduation from dental school)

_____
Name of practice | Practice address

_____
Your duties | Supervisor's name

_____
Dates of employment and hours worked | Reason for leaving

Please explain why you want to apply for licensure in Minnesota.

_____

_____

5. PATIENT RECORDS

A. You must submit 3 separate electronic patient records. You can either email them to the Board or upload them onto a flash drive and include them with your application. Electronic records cannot be encrypted and should have personal identifiers redacted. Submitted records should represent the full scope of clinical practice. Include pre- and post-operative treatment/progress notes and x-rays of diagnostic quality. All 3 cases must be complete and demonstrate minimally acceptable patient records. Refer to Minnesota Rule 3100.9600 for more information on record keeping.

6. DISCLOSURE QUESTIONS

A. Have you ever been disciplined or disqualified as dental professional? If so, attach a statement describing the reason for disciplinary action, the dates, the disposition, and the address of the licensing authority.
☐ No ☐ Yes

B. Are there any criminal charges pending against you? If so, attach a statement detailing the reasons for the charges, the dates, the name and location of the court, and the case number.
☐ No ☐ Yes

C. Have you ever been convicted of a felony, gross misdemeanor, or a misdemeanor? If so, attach a statement detailing the reasons for the charges, the dates, the name of the court, and the case number.
☐ No ☐ Yes

D. Are there any unsatisfied judgments against you that resulted from practicing dentistry? If so, attach a statement detailing the nature of the judgment, the dates, and the reasons for non-payment.
☐ No ☐ Yes

E. Do you have any diagnosed and/or treated mental, physical, or cognitive condition or illness that could affect your ability to practice with reasonable skill and safety that has not been reported to HPSP?
☐ No ☐ Yes

F. Do you have any diagnosed and/or treated substance use disorder that may affect your ability to practice with reasonable skill and safety that has not been reported to HPSP?
☐ No ☐ Yes

7. AFFIDAVIT OF APPLICANT

I certify that I am the person referred to in this application for licensure. I understand that including false information or false documentation in this application may result in the penalty of perjury. I understand that falsifying information to attain licensure is a gross misdemeanor and violates the Dental Practice Act. I certify that the entirety of this application and the attached materials are true and correct. I authorize all persons and organizations to release any requested information, files, or records in connection with this application to the Minnesota Board of Dentistry. **(Complete this section in front of a notary public).**

A. _____

Applicant name (print) | Applicant signature | Date

B. _____

Notary signature | Commission expiration date | Notary stamp

8. CPR CARD

A. Include a photocopy of your current CPR card. The two acceptable courses are the Basic Life Support Provider with the American Heart Association or with the American Red Cross.

9. PHOTOGRAPH

A. Tape a photo of yourself below that is no more than 1 year old. If you have taken the Jurisprudence exam within a year, you may tape a copy of the photograph in the space provided. Photos should be similar in size to a passport photo. Do not use staples. Do not send photographs that have not been taped to the application.

_____For Staff Use Only_____

_____ _____ Fee	_____ _____ Photo
_____ _____ Proof of education	_____ _____ Attachment A
_____ _____ JP	_____ _____ Attachment B
_____ _____ National board	_____ _____ Attachment C
_____ _____ Clinical	_____ _____ Patient records
_____ _____ Affidavit	_____ _____ Other

Disclosure:

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Attachment A: Physical Examination

Minnesota Administrative Rules 3100.1130 and 3100.1400 and Minnesota Statute 150A.06 Subd.1c authorize the solicitation of this information. This information will help determine the nature of a disability or medical condition that may adversely impact one's ability to practice as a dental professional. Completion of this form is voluntary, however the Board may not consider applications for licensure if Attachment A is not submitted. **The physician conducting this examination must complete this form and send it directly to the Board of Dentistry. The Board of Dentistry contact information can be found in the heading of this form. The fax number is 612 617 2260. Examinations must have been completed in the past 12 months.**

Examination Summary

Please summarize any medical findings that might impede the individual's ability to perform as a dental professional with reasonable skill and safety. Please include commentary on past or present mental, physical, psychological, or substance use related concerns. **If no medical concerns exist, please initial in the space provided below**.

_____

_____

_____

Attestation: By signing this document, I certify that I am a duly licensed physician in a United States or Canadian jurisdiction and that I examined the patient listed below.

_____
Patient name (please print) Exam date

_____
Physician name (please print) Credentials/degree

_____
Physician signature Date

_____
Address (street, city, state, zip code)

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Attachment B: Ocular Examination

Eye examinations must have been completed in the past 12 months.

Examination Summary

Eye health:
External: _____ good _____ other
Internal: _____ good _____ other

Recommendations:
_____ No prescription needed
_____ No change to present prescription

New prescription needed:
_____ Single vision
_____ Contact lenses
_____ Bifocals
_____ Trifocals

Additional comments:

_____

_____

Attestation: By signing this document, I certify that I am a duly licensed optometrist or ophthalmologist in a United States or Canadian jurisdiction and that I performed an examination on the patient listed below.

_____
Patient name (please print) Exam date

_____
Ophthalmologist/optometrist name (please print) Credentials/degree

_____
Ophthalmologist/optometrist signature Date

_____
Address (street, city, state, zip code)

Attachment C: Continuing Education

*Courses must have been taken in the past 5 years. Please make copies of this form as needed.

Date of Course	Course Title	Course Description	Sponsor	Hours Attended

RECORDKEEPING CHECKLIST

PATIENT INITIALS: _____

DATES OF SERVICES REVIEWED: _____

Subpart 1. DEFINITIONS.
For the purposes of this part, "patient" means a natural person who has received dental care services from a provider for treatment of a dental condition. In the case of a minor who has received dental care services pursuant to Minnesota Statutes, sections 144.341 to 144.347, patient includes a parent or guardian, or a person acting as a parent or guardian in the absence of a parent or guardian.

Subp. 2. DENTAL RECORDS.	*Present*	*Not Present*	*Not Applic-able*	*Comments*
Maintain dental records on each patient. *Patient information:*				
Subp. 3. PERSONAL DATA. A. Name				
B. Address				
C. Date of birth				
D. If minor, name of parent or guardian				
E. Name/Phone of contact for an emergency				
F. Name of insurance carrier / insurance ID #				
Subp. 4. REASON FOR VISIT.				
Subp. 5. DENTAL HISTORY. Information must include a sufficient amount of data to support the recommended treatment plan.				
NEW 2018: The dental and medical history must be updated to reflect the current status of the patient.				
Subp. 5. MEDICAL HISTORY. Information must include a sufficient amount of data to support the recommended treatment plan.				
NEW 2018: The dental and medical history must be updated to reflect the current status of the patient.				
Subp. 6. CLINICAL EXAM INFORMATION: A. Record of existing oral health status				
B. Radiographs used				
C. Facsimiles or results of other diagnostic aids				
Subp. 7. DIAGNOSIS.				
Subp. 8. TREATMENT PLAN. • Agreed upon				
• Dated (when <u>non</u>-routine/preventive visit)				
• Updated to reflect current status of patient's oral health / treatment				
Subp. 9. INFORMED CONSENT. A. Dentist discussed treatment options, prognosis, risks, and benefits				
B. The patient consented to treatment chosen				

continued, **RECORDKEEPING CHECKLIST**	*Present*	*Not Present*	*Not Applic-able*	*Comments*
Subp. 10. PROGRESS NOTES				
• Legible				
• Chronology of treatment / visits				
A. All treatment provided				
B. All medications used and materials placed				
C. the treatment provider by license number, name, or initials				
D. when applicable, identity of collaborating dentist authorizing treatment by license number				
NEW 2018: E. administration information for nitrous oxide inhalation analgesia, including indication for use, dosage, duration of administration, post treatment oxygenation period prior to discharge, and patient status at discharge.				
Subp. 11. CORRECTIONS OF RECORDS.				
• legible				
• written in ink				
• no erasures or "white-outs."				
• correction crossed-out w/ one single line & initialed				
Subp. 12. RETENTION OF RECORDS.				
• A dentist shall maintain a patient's dental records for at least seven years beyond the time the dentist last treated the patient.				
• In the case of a minor patient, a dentist shall maintain a patient's dental records for at least seven (7) years past the age of majority, 18 = patient age of 25 years.				
Subp. 13. TRANSFER OF RECORDS.				
• Transfer in compliance with Minn. Stat. 144.291 to 144.298 irrespective of status of patient's account.				
• Digital radiographs on compact or optical disc, electronic communication, or printing on high-quality photographic paper.				
• All transferred film or digital radiographs must reveal images of diagnostic quality using proper exposure settings and processing procedures.				
Subp. 14. ELECTRONIC RECORDKEEPING				
• The requirements of subparts 1 to 13 apply to electronic record keeping as well as to record keeping by any other means.				
• When electronic records are kept, a dentist must keep either a duplicate hard copy record or use an unalterable electronic record.				