

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.

_____ App. #
_____ Lic. #
_____ Issued

Licensure by Credentials to Practice Dental Hygiene

Non-refundable Fee: \$268.25 (Application fee: \$175, Background check fee: \$33.25, Initial fee: \$60)

*****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. _____ AAS AS BS 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 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 (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. 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

6. 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

7. 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.

8. 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
_____ Proof of education
_____ JP
_____ National board
_____ Clinical
_____ Affidavit

_____ Photo
_____ Attachment A
_____ Attachment B
_____ Attachment C
_____ Other

Disclosure:

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. Forms must be scanned and emailed directly from an official clinic email address to dental.board@state.mn.us. 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
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Physician name (please print)	Credentials/degree
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Physician signature	Date
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Address (street, city, state, zip code)

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)

