Minnesota Board of Dentistry
335 Randolph Ave., Suite 250
St. Paul, MN 55102
Office: (612) 617-2250
MN Relay Service: (888) 797-1373
www.mn.gov/boards/dentistry

MINNESOTA BOARD OF DENTISTRY

Please read the following information and, **do not submit applications until they are complete, and include all supporting documentation.**

Application:

- 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.

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.

Attestation of Applicant:

- All applicants must complete the Attestation of Applicant.
- Signatures on the Attestation 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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________________ **Appl. #**

________________ **License #**

________________ **Issue Date**

Licensure by Credentials to Practice a Dental Specialty

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) | U.S. Social Security Number (XXX-XX-XXXX)

G. ____
Other names previously used and reason for name change ((if exam scores reflect former name, include legal proof of name change)

2. DENTAL EDUCATION

Have your school send proof directly to Board; **email e-transcript to dental.board@state.mn.us** (or) have your school mail original/official transcripts to the Board.

A. ____ ☐ DDS ☐ DMD ☐ Other ____________
Dental school or program | Degree

B. ____
City, state | Date of graduation

C. ____
Internship, residency, or post-graduate training | Date completed

3. EXAMINATIONS

For Specialty licensure, you may include EITHER your clinical exam OR a specialty certifying board exam. Copies of the National Board, clinical and Jurisprudence exams do not need to be notarized and certified, but do include a printed version of your exam results. Contact the ADA and your regional clinical exam agency office, to ensure that the Board can view your National Board exam scores.

A. Minnesota Jurisprudence Exam
(**must be passed with previous 5 yrs**.)

____
Date Passed (XX/XX/XXXX)

B. National Board Exam
Dentpin: ______________

____
Date Passed (XX/XX/XXXX)

C. Clinical Exam (if applicable)

____
Date Passed (XX/XX/XXXX)

Select exam taken: WREB ☐ CRDTS ☐ NERB ☐ SRTA ☐ Other: _______________

D. Specialty Certifying Board Exam (if applicable)

____
Date Passed (XX/XX/XXXX)

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 letter D.

If you selected yes, you must complete 4B and 4C. Once completed, continue to letter D.

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.

D. Employment History

(**required**: proof of active practice for at least 2,000 hours in the past 36 months or you can use hours earned in a U.S. CODA residency program.)

____

Name of practice (most recent) Practice address

____

Your duties Supervisor's name

____

Dates of employment and total hours worked Reason for leaving

____

Name of practice (if additional employment is applicable) Practice address

____

Your duties Supervisor's name

____

Dates of employment and total hours worked Reason for leaving

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

____

____

5. REFERENCES

A. Include at least two character references from two dentists within your specialty area(s). One letter must be from a dentist practicing in the same specialty area as you and the other letter must be from the director of each specialty program you attended.

6. PHYSICAL/EYE EXAMS

A. Have a licensed physician complete **Form A** (included at end of application), and scan/e-mail to board's general e-mail (dental.board@state.mn.us) OR mail to Board office.

B. Have a licensed ophthalmologist or optometrist complete **Form B** (included at end of application), and include with this mailed application to Board office.

7. DISCLOSURE QUESTIONS

A. Have you ever been disciplined or disqualified as a 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

8. ATTESTATION 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.

A. ____

Applicant name (print) Applicant signature Date

9. 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.

10. GOVERNMENT ISSUED I.D.

A. Include a copy of an official and current U.S. Government issued photo I.D. (Examples; Drivers license, State I.D., Passport, Visa).

_______________________Staff Comments Below_______________________

rev. 1/2022

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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 forlicensure 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 inthe 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
Clinic Name	Clinic Address
Clinic phone number	E-mail contact for clinic

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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 _____ Bifocals
_____ Contact lenses _____ 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)