

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.

_____ Appl.#
_____ License#
_____ Issue Date

Licensure to Practice as a Volunteer

PLEASE TYPE OR PRINT IN INK

Check this box if you have ever held a volunteer license

Please select your license type:

Assistant Dentist Hygienist Dental Therapy

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 any submitted documents 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. _____
Dental school or program City, state

B. AS AAS BS DDS DMD Other _____
Degree Date of graduation

3. VOLUNTEER PRACTICE

A. _____
Name of public health clinic or sponsoring organization

B. _____
Clinic or event address City, state, zip

C. _____
Telephone (include area code) Name of clinic or event coordinator/director

4. PROFESSIONAL BACKGROUND

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

B. License Verification

You must include a license verification from each jurisdiction listed in 4A. 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.

C. Employment History

List each dental practice where you currently practice out of state. Use a separate sheet if necessary.

Primary:

Name of practice	Dates of employment and hours worked
Practice address	Phone number
Supervisor's name	Your duties

Secondary:

Name of practice	Dates of employment and hours worked
Practice address	Phone number
Supervisor's name	Your duties

5. QUESTIONNAIRE

A. I understand that I will receive no compensation as a volunteer.

No Yes

B. I understand that I may not practice until my volunteer license has been granted by the Board of Dentistry.

No Yes

C. I understand that the volunteer license only allows me to practice at the location listed in #3 of this application for 10 days out of this current calendar year.

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. 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. GOVERNMENT ISSUED I.D.

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

_____ Staff Comments Below _____

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