Minnesota Board of Dentistry

University Park Plaza, 2829 University Ave SE, Suite 450
Minneapolis, MN 55414-3249
Website mn.gov/boards/dentistry
Phone 612.617.2250 - Toll Free 888.240.4762 - Fax 612.617.2260
MN Relay Service for Hearing Impaired 800.627.3529

Dear Doctor,

We are enclosing the application form that you requested for licensure by credentials in Minnesota. The requirements for licensure by credentials are outlined on page 6 of the application. Please review them carefully and feel free to call the Board office with any questions. If you do not meet the requirements listed, please call the Board office for direction.

Upon receipt of your completed application, we will send reference forms to each person listed as a reference on your application. Please contact your references to request their immediate attention and return of the reference form to the Board office. Your application will not be considered complete and an interview will not be scheduled until all reference forms have been returned to this office.

The Credentials Committee of the Board meets approximately every six weeks. There is a need to limit the number of interviews scheduled at each credential meeting, due to various time constraints. Interviews are scheduled on a first-come, first-served basis as applications are completed.

Applicants for licensure by credentials shall be given an oral examination (interview) by the Credentials Committee and must satisfactorily respond to questions designed to determine the applicant's knowledge of dental subjects and ability to practice dentistry pursuant to Minnesota Statutes 150A.06, subdivision 4. As you prepare for your interview, please consider that the purpose of the Board is to protect the public. The questions you will be asked are based on the core subject areas of infection control, patient communication, ethics, record keeping, management of medical emergencies and diagnosis and treatment planning. You will be notified about 20 days before the date of your interview. If the interview as scheduled is not convenient for you, we will schedule you for the next Credentials Committee meeting.

With your application, please submit (4) copies of three individual patient records. These records should represent your full scope of clinical general dentistry. The records should be of patients you have treated in the last five years and include pre and post operative treatment/progress notes, and radiographs. The x-rays need to be of diagnostic quality. The cases should be complete to include all aspects of a minimally acceptable patient record. The Committee requires both copies of the patient record in its entirety and translations if records are not in English. The Committee requests that you bring the "original" patient records to the interview.

Please refer to Minnesota rule 3100.9600 (enclosed) for information related to recordkeeping. When available, the Committee encourages you to bring your original patient files to the interview.

Please feel free to contact me at (612) 548-2129, if you have any questions about licensure by credentials or the Jurisprudence Examination.

Joyce Nelson
Director of Licensing
(612) 548-2129
joyce.nelson@state.mn.us

Lic # _____

Issued _____

App # _____

MINNESOTA BOARD OF DENTISTRY

2829 University Avenue SE, Suite 450
Minneapolis, Minnesota 55414
(612) 617-2250 (888) 240-4762
MN Relay Operator for Hearing and Speech Impaired
(800) 627-3529

APPLICATION FOR LICENSURE BY CREDENTIALS TO PRACTICE DENTISTRY

(Requirements listed on page 5 of application)

NON REFUNDABLE FEE DUE - $925.00

(Application Fee $725.00; Background Check Fee $32.00; Initial Fee $168.00)

Instructions. This application is to be completed by dentists applying for licensure by credentials as authorized by Minnesota Statutes §150A.06, Subd. 4 and Minnesota Board of Dentistry Rule 3100.1400. Each item on this application must be answered fully, truthfully, and accurately by the applicant. Fraud or deception in securing a license is a gross misdemeanor and cause for revocation or suspension of a license. If space for any answer is insufficient, the answer may be completed on another piece of paper. Please specify the number of the item, sign it, and attach it to the rest of the application. BE SURE ALL FIVE PAGES OF THIS APPLICATION AND ITS ATTACHMENTS ARE COMPLETED.

Minnesota Government Data Practice Act Notice. This notice is given pursuant to Minnesota Statutes §13.04, subdivision 2, and §13.41, subdivision 2. In order to be licensed, you must submit all the information requested in this application. The Board will use the information to enable it to determine if you meet statutory and rule requirements for licensure. Accordingly, OMISSIONS OR INACCURACIES ARE GROUNDS FOR DENYING YOUR APPLICATION. All data, except your name and address, submitted by you or on your behalf are considered private until you are licensed, at which point the data become public. "Private" is defined by law as information which is accessible only to: you; the staff and members of the Board; the Board's legal counsel; any person to whom the Board must refer the application or parts thereof for verification purposes or for otherwise determining your qualifications; and to persons you designate. In addition, if the matter of your license becomes contested and thereby results either in a contested case hearing or litigation, the data submitted by you or on your behalf may also become accessible to the Minnesota Office of Administrative Hearings, appropriate courts, and those associated with such proceedings, and thereby become public data.

Americans With Disabilities Act. It is the policy of the Minnesota Board of Dentistry to comply with the Americans With Disabilities Act (ADA). The ADA provides, in part, that qualified individuals with disabilities shall not be excluded from participating in or be denied the benefits of any program, service, or activity offered by the Minnesota Board of Dentistry. If you require additional information about the Minnesota Board of Dentistry's ADA policy please contact the Minnesota Board of Dentistry's designated ADA coordinator.

*****THIS APPLICATION WILL BE COPIED FOR REVIEW - PLEASE TYPE OR PRINT LEGIBLY IN BLACK INK*****

BACKGROUND

1.	Name (last, first, middle)		Today's Date
2.	Primary Practice Address (street) (required if employed)	City, State, Zip	
3.	Mailing Address (street)	City, State, Zip	
4.	Telephone (include area code) ( )	Email Address (mandatory)	
5.	Sex ❑ Male ❑ Female	Birth date	Social Security No. _____--_____--_____
6.	Other name(s) by which you are or have been known and reasons for change		

DENTAL EDUCATION

7.	Dental School	
8.	Location	Date of Graduation (month, day, year)

9.	Degree (attach one of the following: notarized copy of diploma, OR original official transcript, OR original certificate/letter of graduation): ❑ D.D.S. ❑ D.M.D. ❑ Other (specify) _____
10	Internship, Residency, or Post-Graduate Training Date Completed (month, day, year)
11	Other College or University Education (include dates and degrees earned)

EXAMINATIONS

	Month	Day	Year
12. NATIONAL BOARD EXAMINATION - Date Completed **(Attach a notarized copy of National Board certificate or card) .....**			
13. CLINICAL EXAMINATION FOR LICENSURE - Date Completed **(Attach a notarized copy of letter or certificate. Canadian Applicants should submit a notarized copy of their National Dental Examining Board of Canada certificate).....**			
14. MINNESOTA JURISPRUDENCE EXAMINATION - Date Completed **(Attach an original or notarized copy of the Exam results. Examination on the Rules of the Minnesota Dental Practice Act must be passed within 5 years prior to application.) .....**			

15. List other national, regional, state, or Canadian Province licensure examinations (give names and dates of each examination and indicate any failures).

PROFESSIONAL BACKGROUND

16. List each state, Canadian Province or country, where you are or have held a license as a (general dentist, resident, faculty, specialist, hygienist, or licensed/registered dental assistant. (if so, please complete #17) _____

_____

17.

AFFIDAVIT OF LICENSURE

This Affidavit of Licensure, copy thereof, or official letter must be completed by the licensing authority of each state, province and country listed in item 16. The original document, containing an official signature and seal, must be submitted.

I, _____ Secretary/Chair of the _____

_____ hereby certify that _____

was granted license number _____ to practice dentistry in _____
(state/province/country)

on the _____ day of _____, _____, and that this license is: ❑ active ❑ terminated _____.
(year)

I further certify that disciplinary action: ❑ has been taken against said licensee* ❑ has not been taken against said licensee; **AND**

❑ is pending* ❑ is not pending ❑ that pending disciplinary action cannot be confirmed or denied.

(SEAL)

Dated this _____ day of _____, 20_____.

Signed _____
(Signature of Secretary or Chair)

Title _____

**Please attach a statement pertaining to disciplinary action, if any.*

DISCLOSURE QUESTIONS

	YES	NO
18. Have you ever been denied a license to practice dentistry in another state or other country? (*If so, attach a statement indicating the location, date and reason for such denial.)*	❑	❑
19. Have you ever been suspended from practice, reprimanded, censured or otherwise disciplined or disqualified as a dentist or other professional? (*If so, attach a statement indicating reason for action, dates, disposition and address of licensing authority in possession of record.)*	❑	❑
20. Do you have any criminal charges pending against you? *(If so, attach a statement giving full details including reason, dates, name and location of court, and case number.)*	❑	❑
21. Have you ever been convicted of a felony, gross misdemeanor or misdemeanor? *(If so, attach a statement giving full details including reason, dates, name and location of court, and case number.)*	❑	❑
22. Are there any unsatisfied judgments against you that resulted from the practice of dentistry? *(If so, attach a statement giving details including nature of judgment, dates and reasons for non-payment.)*	❑	❑
23. Based on your assessment or that of another professional, does your use of alcohol or drugs, or the existence of a physiological or psychological medical condition, in any way impair or limit your ability to practice dentistry with reasonable skill and safety? If yes, please 1) explain the use or medical condition, and 2) explain whether the impairment(s) or limitation(s) caused by your use of alcohol or drugs or by the existence of your physiological or psychological medical condition are reduced or ameliorated because you receive ongoing treatment or because of the manner in which you have chosen to practice . *(Please provide these explanations on a separate attachment to your application.)*	❑	❑
24. Are you a member of a dental association or society? (If so, give names and locations). _____	❑	❑

_____

25. EMPLOYMENT – Professional (Active practice of 2,000 hours within the last 36 months)

	(1)	(2)	(3)
Name of Practice			
Address			
Dates (from-to)			
Supervisor			
Duties			
# of Hours Worked			
Reason for leaving			

26. EMPLOYMENT – Other (Since graduation from dental school)

Name of Practice			
Address			
Dates (from-to)			
Supervisor			
Duties			
Reason for leaving			

27. Reasons for applying for licensure in Minnesota: _____

_____

TESTIMONIALS AND REFERENCES:

- **You must provide two testimonials and three references with your application.**
- **<u>Testimonials and references must be dentists</u> with whom you are acquainted (for at least one year) but not related to and are not included elsewhere on this application.**

<u>TESTIMONIALS</u>

28. This certifies that I have been personally acquainted with _____ for _____years, that I know him/her to be of good professional character and hereby recommend him/her to the Minnesota Board of Dentistry for licensure to practice dentistry in Minnesota.

Name _____Address _____

City _____ State _____ Zip _____ Phone # _____

Dental school graduated from _____ on _____/_____/_____

Licensed in (state or province) _____License Number _____

_____
(Original Signature) *(Date)*

29. This certifies that I have been personally acquainted with _____ for _____years, that I know him/her to be of good professional character and hereby recommend him/her to the Minnesota Board of Dentistry for licensure to practice dentistry in Minnesota.

Name _____Address _____

City _____ State _____ Zip _____ Phone # _____

Dental school graduated from _____ on _____/_____/_____

Licensed in (state or province) _____License Number _____

_____
(Original Signature) *(Date)*

<u>REFERENCES</u>

30. Name _____ Occupation _____
Address _____
City _____ State _____ Zip _____
Phone # _____ Email:_____

31. Name _____ Occupation _____
Address _____
City _____ State _____ Zip _____
Phone # _____ Email:_____

32. Name _____ Occupation _____
Address _____
City _____ State _____ Zip _____
Phone # _____ Email:_____

33. **PHOTOGRAPH**

For identification purposes, please tape one passport size photograph here, taken within the last six months.

REMINDERS	YES	NO
Is the required statement from a licensed physician attesting to your physical and mental condition attached *(physical exam must have been completed within the previous 12 months)* (Attachment A)?	❑	❑
Is the required statement from a licensed ophthalmologist or optometrist attesting to your visual acuity attached *(vision exam must have been completed within the previous 12 months)* (Attachment B)?	❑	❑
Is attachment C completed with continuing dental education courses taken in the last five years?	❑	❑
Are the required patient records, including radiographs and diagnostic materials, attached?	❑	❑

AFFIDAVIT OF APPLICANT

34. STATE OF _____)
COUNTY OF _____) ss.

I, _____, the applicant being first duly sworn, certify that I am the person referred to in this application for dental licensure, that under penalty of perjury all the information contained in this application and in any attachment or additional document submitted herewith is true and correct and that all persons and organizations, whether public or private, are authorized to release to the Minnesota Board of Dentistry any information, files or records requested in connection with this application.

APPLICANT'S ORIGINAL SIGNATURE _____
(Sign before a Notary Public)

Sworn to before me this _____ day of _____, 20 ____

My Commission expires _____ *(SEAL)*

_____
Notary Public Signature

REQUIREMENTS FOR LICENSURE BY CREDENTIALS AS A DENTIST:

A) Be a graduate of a dental school accredited by the Commission on Accreditation;

B) Hold or have held a license to practice dentistry in another state or Canadian Province, in good standing.

C) Have passed a clinical examination for licensure in another state or Canadian Province where the licensure requirements are substantially equivalent to those of Minnesota (Canadian applicants should submit a notarized copy of their National Dental Examining Board of Canada certificate);

D) Have been in active practice in another state, Canadian Province, or United States government service at least 2,000 hours within last 36 months;

E) Submit a physician's statement attesting to the applicant's physical and mental condition (Attachment A);

F) Submit a licensed ophthalmologist's or optometrist's statement attesting to the applicant's visual acuity (Attachment B);

G) Submit summary of continuing dental education courses taken in the last five years (Attachment C);

H) Submit electronic copy or four copies of three complete patient records to include all radiographs (of diagnostic quality) and diagnostic materials on a sample of patients treated during the three to five years preceding receipt of application.

I) Submit the licensure by credential application fee in U.S. Funds. Your check or money order should be payable to the Minnesota Board of Dentistry;

J) Be examined and receive a passing score on an examination covering the Rules of the Board and the Minnesota Dental Practice Act (Minnesota Jurisprudence Examination). *Information on the Jurisprudence Exam may be found at http://mn.gov/health-licensing-boards/dentistry/licensure/jurisprudence.jsp*;

K) Submit a completed application form; **including a photocopy of current BLS Healthcare provider CPR.**

L) Appear before the Credentials Committee of the Board for a personal interview and satisfactorily respond to questions designed to determine your knowledge of dental subjects and ability to practice dentistry pursuant to Minnesota Statutes 150A.06, subdivision 4. Questions may be based on the patient records submitted with the application (see requirement G).

NOTES – PLEASE READ CAREFULLY:

1. Please be sure all FIVE pages of this application are completely filled out. Incomplete applications WILL be returned to you without action pursuant to Minnesota Rule 3100.1500.

2. Remember to attach the required original documents or NOTARIZED copies listed in items 9, 12, and 13. *(A notarized copy is a photocopy that is certified to be a true copy of the original document and is signed and stamped/sealed by a notary public.)*

3. The examination on the Rules of the Board and the Minnesota Dental Practice Act (item 14)

4. Your check or money order, in the amount listed on page 1 of this application, should be payable to the **Minnesota Board of Dentistry**. Pursuant to Minnesota Statutes Section 604.113, there will be a $20 service charge on all checks not honored by your bank.

5. Following receipt of the application and verification of the applicant's credentials and references, the applicant will be notified as to the date and location of the personal interview with the Board.

6. Your entire application will be copied for review by our Committee members. Please complete the application and its attachments using black ink and print or type all information.

If you intend to provide Nitrous Oxide, Conscious Sedation, Contracted Sedation Services or General Anesthesia, you must fill out the proper application *(Application form for Nitrous Oxide NOT required for graduates of the University of Minnesota Dental program after May 2008).* **Applications can be found under Forms on our website: http://mn.gov/boards/dentistry/forms/**

_ PLEASE DO NOT WRITE BELOW _

____ DIP ____	____ PR 3 YRS ____	____ PHY STMT ____	____ REF LTRS ____
____ NATL ____	____ PHOTO ____	____ EYE STMT ____	____ AFFIDAVIT ____
____ CLINC ____	____ FEE ____	____ CDE ____	____ N.P.D.B. ____
____ JURIS ____	____ PT RECDS ____	____ SPEC.REF ____	____ DIR.LETTER ___

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ATTACHMENT A

Application for Licensure by Credentials in Minnesota

REPORT OF EXAMINING PHYSICIAN
Physical Exam must have been completed within the last 12 months

I, _____, a duly licensed physician in

the State of _____ have this

_____ day of _____, _____
(month) (year)

Examined _____.
(name of applicant)

My examination reveals that the examinee is not chemically dependent, nor do I find that the examinee has any physical or mental disabilities, except: _____

_____

_____.

This examination was made at _____
(clinic name and address)
_____,

the State of _____.

_____
Signature of Physician

_____ _____
Physician Name Credentials/Degree

_____
Address

_____
City, State, Postal Code

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ATTACHMENT B

Application for Licensure by Credentials in Minnesota

EYE EXAMINATION REPORT
Vision exam must have been completed within the last 12 month

_____ _____
Examinee Date of Examination

This is a summary of the results of the examination of your eyes and vision. Items checked apply to you.

1. Health of eyes:

External: good _____ other _____

Internal: good _____ other _____

2. Recommendations (check one below):

- No lenses needed: _____
- No change in present lenses needed: _____
- New lenses recommended:

Single vision _____ Bifocals _____
Single vision sunglasses _____ Bifocal sunglasses _____
Contact lenses _____ Trifocals_____

Additional Comments:
_____

_____
Signature of Ophthalmologist or Optometrist

_____ _____
Ophthalmologist or Optometrist Name Credentials/Degree

_____
Address

_____
City, State, Postal Code

ATTACHMENT C

Application for Licensure by Credentials in Minnesota

Record of Continuing Dental Education Taken within the Past 5 years:

(Please make copies of this page as needed.)

Date of Course	Course Title	Detailed Course Description	Name & credentials of Course Presenter	Hours Attended