



General Dental Licensure Application Checklist

You **must** submit the following documents at the time of application for licensure. Use this checklist to ensure that you have included the required documents. Applications with documents missing or not acceptable will be mailed back to you. **NOTE TO NOTARIES:** Our Board requires a statement from you, along with your stamp/signature that states: "This is a true copy of the original".

- Completed Application Form (*All 4 pages complete*)
- Diploma (*Notarized copy*)
- National Board Exam (*Original or notarized copy*)
- Clinical Exam (*Original or notarized copy*)
- Minnesota Jurisprudence Exam (*Original or notarized copy*)
Information on the Jurisprudence Exam may be found at
<http://mn.gov/health-licensing-boards/dentistry/licensure/jurisprudence.jsp>
- CPR Card (*Copy, ONLY American Heart Association or American Red Cross healthcare provider courses are acceptable*)
- Check or money order payable to the Minnesota Board of Dentistry for the amount listed on Page 1 of the application.

The following items **must** be included if they apply to you:

- Affidavit of Licensure (*Original document, required only if you are or have been licensed as a general dentist, resident, faculty, specialist, hygienist, or registered/licensed dental assistant in another state, Canadian Province, or country*)
- Response to disclosure questions (*Required only if you answer Yes to any of questions 18-22*)

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*). These forms can be found on our website under FORMS: <http://mn.gov/boards/dentistry/forms/>

EXAMINATIONS – All exams must be passed within 5 years prior to application

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 passing one of the following:
 • Board accepts **CRDTS, SRTA, CITA, WREB, CDCA/ADEX**.....
(all components of the exam chosen must have been completed)
 • National Dental Examining Board (NDEB) of Canada, if
 o a graduate of Accredited Canadian Dental school, or
 o a graduate of Univ. of MN on or after 5/2010
14. MINNESOTA JURISPRUDENCE EXAMINATION - Date Completed
Attach an original or notarized copy of proof of passing the Exam.....

Month	Day	Year

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 license/registered dental assistant. (if so, please complete #17) _____

17. **AFFIDAVIT OF LICENSURE**

This Affidavit of Licensure, copy thereof, or official letter that includes this information 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 of _____
 on the _____ day of _____, _____, and that this license is: active terminated _____.
(date) (month) (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

- | | <u>YES</u> | <u>NO</u> |
|---|--------------------------|--------------------------|
| 18. 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.) | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. 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.) | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. 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.) | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. 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.) | <input type="checkbox"/> | <input type="checkbox"/> |

22. 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.)

23. **TESTIMONIALS - FROM DENTISTS WITH WHOM YOU ARE ACQUAINTED (for at least one year) BUT NOT RELATED TO AND NOT INCLUDED ELSEWHERE ON THIS APPLICATION (two required):**

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)

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)

24. **REFERENCES -- Acquaintances**

Persons with whom you are personally acquainted but not related to and not included elsewhere on this application (two required).

Name _____ Occupation _____

Address _____

City _____ State _____ Zip _____ Phone _____

Name _____ Occupation _____

Address _____

City _____ State _____ Zip _____ Phone _____

25. **REFERENCES -- Dentists**

Dentists with whom you are personally acquainted but not related to and not included elsewhere on this application (two required).

Name _____ Occupation _____

Address _____

City _____ State _____ Zip _____ Phone _____

Name _____ Occupation _____

Address _____

City _____ State _____ Zip _____ Phone _____

26. **PHOTOGRAPH**

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

AFFIDAVIT OF APPLICANT

27. 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

NOTES – PLEASE READ CAREFULLY:

- a. Please be sure all FOUR pages of this application are completely filled out. Incomplete applications WILL be returned to you without action pursuant to Minnesota Rule 3100.1500.
- b. Remember to attach the required original documents or NOTARIZED photocopies listed in items 9, 12, 13 and 14. (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.)
- c. **Photocopy of current BLS Healthcare provider CPR certification from AHA or ARC.**
- d. Your check or money order 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.

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----- PLEASE DO NOT WRITE BELOW -----

____ CL. EX. ____
____ NAT.EX. ____
____ JURIS ____

____ PHOTO ____
____ AFFID. ____
____ DIPL. ____

____ TESTIMONIALS
____ FEE
____ OTHER