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

APPLICATION FOR DENTAL THERAPIST LICENSE RENEWAL

--INSTRUCTIONS--

1. Your completed renewal application and renewal fee must be received or legibly postmarked on or before **the due date.** A penalty fee will be applied to all **incomplete** applications if not received or legibly postmarked on or before the due date. Mail your completed application and proper fee to the address in the letterhead.

2. Applications are **incomplete** unless all required information **including signature** and the correct fee are received or legibly postmarked on or before the due date.

3. If you are in active clinical practice, you must provide the primary practice address (Minn. Stat. 214.073).

4. If you use one check to pay for more than one renewal, **ALL** renewal applications must be complete **including signatures** or **ALL** renewal applications will be returned. The penalty fee will apply on **ALL** renewals if they are not returned or legibly postmarked on or before the due date.

5. Applications are **incomplete** when checks are not honored by your bank. Pursuant to Minn. Stat. 604.113, there will be a $20 service charge on all checks not honored by your bank. Checks should be made payable to the Minnesota Board of Dentistry. Foreign checks should state the fee in *U.S. dollars*. **DO NOT SEND CASH BY MAIL.**

6. Failure to apply for renewal of your license or to voluntarily terminate your license may result in the termination of your license.

7. Minnesota law requires you to inform the Board of name and/or address changes in writing within thirty (30) days of a change. If you have a name change, you need to complete and notarize the name change form (located on Board website under Forms).

8. Minn. Stat. 13.41, subd. 2, item B requires a licensee to provide a telephone number at which the licensee can be contacted in connection with the license.

* Minn. Rule 3100.1700, subp2 requires that you maintain a consecutive and current CPR certification. "CPR" refers to a comprehensive hands-on course for a health care provider that includes: cardiopulmonary resuscitation on an adult, child, and infant; two-person rescuer; barrier mask or bag for ventilation; foreign body airway obstruction; and automated external defibrillation. A CPR certificate shall be obtained through the American Heart Association health care provider (BLS) course or the American Red Cross professional rescuer (BLS) course.

To RENEW ONLINE

Go to Board's website under

Online Services (http://mn.gov/boards/dentistry/onlineservices/onlinerenewal.jsp)

- Must have an active dentist, dental hygiene, dental therapist, dental assistant or limited general license.
- Must have an active VISA, MasterCard or Discover credit card.

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For Biennial Period _____ through _____

Name First	M.I.	Last	License #:

Mailing Address (street address)		
City	State	Zip
Daytime Phone	Alternate phone	
Email (**mandatory**)	County	

Practice Name and Address: (mandatory if in clinical practice)		
Street Address		
City	State	Zip
Daytime Phone	Email	

1. Please check the correct practice status below: ❑ Active Practice In State (Currently in clinical practice IN MINNESOTA). ❑ Active Practice Out State (Currently in clinical practice OUTSIDE MINNESOTA). ❑ Active Not Practicing In State (Currently not in clinical practice IN MINNESOTA). ❑ Active Not Practicing Out State (Currently not in clinical practice OUTSIDE MINNESOTA).	
2. Are you current in AHA or ARC Healthcare Provider (BLS) CPR*?	❑ YES ❑ NO
3. Renewal Fee - Due Date: **Last Day of Your Birth Month:**	**$200.00**
4. **Notice of Late Fee:** If your correctly completed application and renewal fee are not received or postmarked by the due date, add **$50.00 late fee**.	**$**
5. You will receive one renewal certificate automatically. • I would like an additional _____ duplicate certificate(s).....@ $10 each • I would like _____ duplicate license(s).....@ $35 each	**$** **$**
6. **Total Amount Enclosed:** Make your check or money order payable to: **Minnesota Board of Dentistry**	**$**

Rights of Subject

Under Minnesota Statute 13.41, subdivision 2, information you provide in this renewal application except for your name and address is classified as private, that is, accessible only to you, the staff and members of the Board, the Board's counsel, and persons you designate, while you remain an applicant for license renewal. 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.

The purpose and intended use of this information is for license renewal and to assist the Board to verify compliance with other provisions of Minnesota Statutes 150A.01 to 150A.31 and Minnesota Rules 3100.0100 to 3100.9600. You are not legally required to provide this information, but failure to do so may affect the renewal of your license. Practicing without a renewed license is unlawful under Minnesota Statute 150A.

License Renewal Questions

If your response to any license renewal question indicates that you may have engaged in conduct that constitutes a violation of Minnesota Statutes or Rules governing the practice of dentistry, the matter may be referred for investigation by a Committee of the Board.

DISCLOSURES (The following questions apply to actions in Minnesota and all other jurisdictions **during or since your most recent** Minnesota dental renewal.)

	Yes	No
1. Have you ever been suspended from practice, reprimanded, censured or otherwise disciplined or disqualified as a dental or other professional?	❑	❑
2. Have you been convicted or adjudicated of a felony, gross misdemeanor or misdemeanor?	❑	❑
3. Do you have any criminal charges pending against you?	❑	❑
4. Are there any unsatisfied judgments against you that resulted from the practice of dentistry?	❑	❑
5. Based on your assessment or that of another professional, has your use of alcohol or drugs, or the existence of a physiological or psychological medical condition, in any way ever impaired or limited your ability to practice your dental profession with reasonable skill and safety, or has anyone expressed concern about your use of alcohol or chemical substances, including prescription medications? If you have signed a participation agreement with HPSP, you may answer "No" to this question.	❑	❑

Professional Development

6. I attest that I have or will have completed the requirements of a minimally acceptable Professional Development portfolio by the expiration date of my renewal cycle.	❑	❑

****REQUIRED****

_____ (____) _____

*Signature **(original required)*** *Daytime phone*

VOLUNTARY TERMINATION ONLY

I no longer intend to maintain my license and hereby voluntarily terminate it. I understand that if I terminate my license, no renewal fee is required and my authority to practice dentistry in Minnesota ends.

Signature (original): _____ Date: _____

Minnesota Department of Health

OFFICE OF RURAL HEALTH AND PRIMARY CARE

Healthcare Workforce Questionnaire

Available at:

http://www.health.state.mn.us/divs/orhpc/workforce/database/survey.html

Please complete the healthcare workforce questionnaire available at the link above. The Minnesota Department of Health (MDH) uses the information to guide state healthcare workforce policy and to understand emerging trends in healthcare, ensuring all Minnesotans can access physical, oral, and behavioral healthcare.

You are required by law to provide this information, per Minnesota Statutes 144.051 and 144.052 and Minnesota Rules 4695.0100-4695.0300.

The questionnaire is independent of licensure or registration and the completion of it has no bearing on license or registration renewal.

For any assistance or questions about this questionnaire, please call MDH at (651) 201-3838 or toll free at (800) 366-5424. You may also email us at health.orhpc@state.mn.us.

Thank you for taking the time to complete the questionnaire online.