

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 TO PRACTICE AS A GUEST DENTAL HYGIENIST

NON REFUNDABLE APPLICATION FEE - \$82.00

(Application Fee \$50.00; Background Check Fee \$32.00)

Instructions. 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 FOUR 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 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.

PLEASE TYPE OR PRINT IN INK

BACKGROUND

1.	Name (last, first, middle)	Today's Date	
2.	Home Address (street)	City, State, Zip	
3.	Telephone (include area code) ()	Email Address (mandatory)	
4.	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Birth date	Social Security Number - -
5.	Other name(s) by which you are or have been known and reasons for change		

DENTAL HYGIENE EDUCATION

6.	Dental Hygiene School		
7.	Location	Date of Graduation (month, day, year)	
8.	Degree (attach a notarized copy of diploma): <input type="checkbox"/> A.A.S. <input type="checkbox"/> A.S. <input type="checkbox"/> B.S. <input type="checkbox"/> Other (specify):		
9.	List other College or University Education (include dates and degrees earned).		

NAME AND LOCATION OF GUEST LICENSURE PRACTICE

10.	Name of public health clinic:	
11.	Practice Address (street)	City, Zip
12.	Telephone (include area code) ()	Supervisor's Name

- | | | <u>YES</u> | <u>NO</u> |
|-----|---|--------------------------|--------------------------|
| 13. | I agree to treat indigent patients who meet the eligibility criteria established by the public health clinic listed in item 10. | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. | I understand that a guest license to practice dental hygiene in Minnesota allows me to practice only at the specific location listed in item 11. | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. | I understand that, should the public health clinic in which I practice cease to operate, my guest license will be revoked. It will be my responsibility to notify the Board of all changes in the clinic operation with regard to my license. | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. | I understand that it will be my responsibility to notify the Board immediately if my license in a border state is terminated or disciplined for any reason. | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. | I understand that while practicing under a guest license, I have the same obligations as a dental hygienist who is licensed in Minnesota and I am subject to the laws and rules of Minnesota and the regulatory authority of its Board. | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. | I have included a letter from the clinic listed in item 10 that: (i) includes a statement, program description or other indication that the clinic provides dental care to patients who have difficulty accessing dental care; and (ii) provides a copy of the IRS letter that indicates that the clinic has been established by a nonprofit organization that is tax exempt under chapter 501 (c) (3). | <input type="checkbox"/> | <input type="checkbox"/> |

19. EMPLOYMENT – Professional (List each dental practice where you currently practice dentistry. Use a separate sheet if necessary.)

	Primary	Secondary	Other
Name of Practice	_____	_____	_____
Address	_____	_____	_____
	_____	_____	_____
Phone No.	_____	_____	_____
Supervisor	_____	_____	_____
Duties	_____	_____	_____
Average Hours	_____	_____	_____

PROFESSIONAL BACKGROUND

20. Name any state/jurisdiction where you have ever been licensed/regulated in the dental profession: _____

21.

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 circled in item 20. The original, containing an official signature and seal, must be submitted.

I, _____ Secretary/Chair of the _____
 _____ hereby certify that _____
 was granted license number _____ to practice dental hygiene 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.

Dated this _____ day of _____, 20____.

(SEAL)

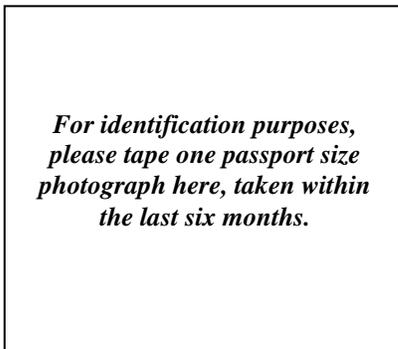
Signed _____
 (Signature of Secretary or Chair)

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

- | | <u>YES</u> | <u>NO</u> |
|---|--------------------------|--------------------------|
| 22. Have you ever been suspended from practice, reprimanded, censured or otherwise disciplined or disqualified as a dental hygienist or other professional? <i>(If so, attach a statement indicating reason for action, dates, disposition and address of licensing authority in possession of record.)</i> | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. Do you have any criminal charges pending against you? <i>(If so, attach a statement giving full details including reason, dates, name and location of court, and case number.)</i> | <input type="checkbox"/> | <input type="checkbox"/> |
| 24. Have you ever been convicted of a felony, misdemeanor or gross misdemeanor? <i>(If so, attach a statement giving full details including reason, dates, name and location of court, and case number, and terms of resolution.)</i> | <input type="checkbox"/> | <input type="checkbox"/> |
| 25. Are there any unsatisfied judgments against you that resulted from the practice of dental hygiene? <i>(If so, attach a statement giving details including nature of judgment, dates and reasons for non-payment.)</i> | <input type="checkbox"/> | <input type="checkbox"/> |
| 26. 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 dental hygiene 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. <i>(Please provide these explanations on a separate attachment to your application.)</i> | <input type="checkbox"/> | <input type="checkbox"/> |

27. **PHOTOGRAPH**



28. ATTESTATION OF APPLICANT

Yes No I attest to the fact that I am fully knowledgeable of the laws of Minnesota including the delegation of duties to allied staff and all other Minnesota Statutes and Rules.

Yes No I attest to my understanding that I may not practice as a dental profession in Minnesota unless and until I receive confirmation from the Board of Dentistry that my Guest Hygiene license has been issued.

AFFIDAVIT OF APPLICANT

29. STATE OF _____)
 COUNTY OF _____) ss.

I, _____, the applicant being first duly sworn, certify that I am the person referred to in this application for guest dental hygiene 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 item 6. *(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. Remember to attach the required letter from the clinic you will work in (item 18) and an "Affidavit of Licensure" (item 21) from every jurisdiction you have ever been licensed/regulated in.
- e. 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.
- f. If you fail to notify the Board of changes in operation of the public health clinic in Minnesota that you practice at with regards to your license, or if you fail to notify the Board of the termination or discipline of your licensure in a state/jurisdiction, you may be subject to disciplinary action.

APPLICANT NOTES

QUESTION NUMBER

ANSWER

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

____ DIP _____
 ____ EXAMS _____
 ____ JURIS _____

____ PHOTO _____
 ____ OTHER _____
 ____ FEE _____

____ LOG _____
 ____ COMP ENT _____
 ____ CERT _____