

Lic # _____
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## 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 VOLUNTEER GUEST:

DENTIST

DENTAL HYGIENIST

DENTAL ASSISTANT

Please check this box, if you have ever held a VOLUNTEER GUEST LICENSE Previously.

**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 EDUCATION

6.	Dental/Dental Hygiene/Dental Assisting School	
7.	Location (City, State)	Date of Graduation (mo, day, year)
8.	Degree (attach a notarized copy of diploma or certificate of completion – if applicable):	

**NAME AND LOCATION OF VOLUNTEER GUEST LICENSURE PRACTICE**

9.	Name of public health clinic or sponsoring organization promoting volunteer opportunity:	
10.	Clinic or Event Address (street)	City, Zip
11.	Telephone (include area code) (        )	Name (Clinic or Event Coordinator/Director)

- |     |  | <u>YES</u>               | <u>NO</u>                |
|-----|--|--------------------------|--------------------------|
| 12. | I agree to treat all patients who meet the eligibility criteria established by the clinic/sponsoring organization.   | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. | I understand that a guest license to practice dentistry in Minnesota allows me to practice only at the specific location listed in item 10 .   | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. | I understand that It will be my responsibility to notify the Board of any changes in the clinic operation/sponsoring organization with regard to my license.   | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. | I understand that it will be my responsibility to notify the Board immediately if my license in any state or other jurisdiction is terminated or disciplined for any reason.   | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. | I understand that while practicing under a guest license, I have the same obligations as a dental professional 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"/> |
| 17. | I have included a letter from the clinic/sponsoring organization that includes a statement, program description or other indication that the clinic/organization provides dental care to patients who have difficulty accessing dental care; and 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"/> |

18. EMPLOYMENT – Professional (List each dental practice where you currently practice your profession. Use a separate sheet if necessary.)

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

**PROFESSIONAL BACKGROUND**

19. Name any state where you currently practice your profession or previously held a license or been regulated. \_\_\_\_\_

20.

**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 19. 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 dentistry/dental hygiene/dental assisting 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\_\_\_\_.

Signed \_\_\_\_\_  
(Signature of Secretary or Chair)

(SEAL)

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

- |   | <u>YES</u>               | <u>NO</u>                |
|---|--------------------------|--------------------------|
| 21. Have you ever been suspended from practice, reprimanded, censured or otherwise disciplined or disqualified as a dental 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"/> |
| 22. 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"/> |
| 23. Have you ever been convicted of a felony, misdemeanor or gross misdemeanor? (If so, attach a statement giving full details including reason, dates, name and location of court, and case number, and terms of resolution)   | <input type="checkbox"/> | <input type="checkbox"/> |
| 24. 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"/> |
| 25. 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 impaired or limited 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.) | <input type="checkbox"/> | <input type="checkbox"/> |

26. **PHOTOGRAPH**

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

**27. 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 related to the practice of the dental professions.
- Yes  No I attest to my understanding that I may not practice a dental profession in Minnesota unless and until I receive confirmation from the Board of Dentistry that my Volunteer Guest License has been issued.

**AFFIDAVIT OF APPLICANT**

28. 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/dental hygiene/dental assisting volunteer 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 9) and an "Affidavit of Licensure" (item 20) from every state/jurisdiction where you currently work or have ever been licensed/regulated.
- e. If you fail to notify the Board of changes in operation of the clinic or sponsoring organization identified in this application, or if you fail to notify the Board of the termination or discipline of your licensure in another 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- 6/29/16 \_\_\_\_\_