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 Faculty Dentist:

Minnesota Statutes section 150A.06, subdivision 1a and Minnesota Rule 3100.1150, subpart 1 require that a faculty member must be licensed by the board in order to practice dentistry. A faculty member who is not licensed to practice dentistry in Minnesota shall obtain from the Minnesota Board of Dentistry a license to practice dentistry as a full or limited faculty dentist.

A full faculty dental license is different from the limited faculty dental license because you may practice privately. However, you are required to hold at least a fifty percent appointment within an accredited Minnesota dental, dental hygiene or dental assisting program *for the purposes of teaching and research only*. If, in the course of your employment as a faculty dentist, your appointment devoted to teaching and research goes below fifty percent, you are required to notify the Board of Dentistry of that fact and to apply for a limited faculty dentist license. With a limited faculty dentist license you will not be allowed to have an intramural or private practice. Licensees who disregard this requirement may be disciplined or have their license revoked.

Please indicate which of the above mentioned applications you wish to receive to become licensed as a faculty dentist in Minnesota. You will need to complete the application and return it to the Minnesota Board of Dentistry with all applicable attachments and the application fee. You must have a faculty dentist license issued to you before you begin treating patients.

Pursuant to Minnesota Statute 150A.06, subdivision 1a and Minnesota Rule 3100.1150, subpart c, you are required to submit a letter with this application from the Dean or Program Director of the accredited dental, dental hygiene, or dental assisting program in which you work. The letter must provide the following information:

(1) the applicant's full name;
(2) the applicant's social security number;
(3) the applicant's home and work address;
(4) a statement that the applicant is a member of the faculty and practices dentistry within the school or its affiliated teaching facilities with at least a fifty percent appointment for purposes of instruction or research only;
(5) the dates of the applicant's employment by the school of dentistry;
(6) a statement that the applicant has been notified of the need to be licensed by the board as a faculty dentist; and
(7) a statement that the information provided is accurate and complete.

You must also pass the Minnesota Jurisprudence Examination before you can apply for your license. This examination covers the statutes and rules that apply to the practice of dentistry, dental hygiene, and dental assisting in Minnesota. Information on the Jurisprudence Exam may be found at http://mn.gov/boards/dentistry/licensure/jurisprudence.jsp

If you have any questions about obtaining a full/limited faculty dentist license, the application, or the Jurisprudence Examination, please feel free to contact me.

Sincerely,

Joyce Nelson
Licensing Supervisor
(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 TO PRACTICE DENTISTRY AS A LIMITED FACULTY DENTIST

(Pursuant to Minnesota Rule 3100.1150, subpart 1)

NON REFUNDABLE FEE DUE - $172.00

(Application Fee $140.00; 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. 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.

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 becomes 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 -

Date:

BACKGROUND

1.	Name (last, first, middle)		
2.	Name of program and address		City, State, Zip
3.	Applicant mailing address (street)		City, State, Zip
4.	Telephone (include area code)		Email address (mandatory)
5.	Sex ❑ Male ❑ Female	Birth date	Social Security Number _____--_____--_____
6.	Other name(s) by which you are or have been known and reasons for change:		

NOTES:

- Please be sure **ALL** pages of this application are completely filled out. Incomplete applications **WILL** be returned to you for completion pursuant to Minnesota Rule 3100.1500.
- Remember to include proof of employment from the Dean or Program Director at your school (Item A on the last page of this application).
- Remember to include NOTARIZED copies of the documents 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.)*
- You may contact the Board office for exam information and an application and schedule to take the Minnesota Jurisprudence exam (Item 13).
- Your check or money order, in the amount listed at the top of this page should be in U.S. funds payable to the Minnesota Board of Dentistry. Pursuant to Minnesota Statute § 332.50, there will be a $20 service charge on all checks not honored by your bank.

DENTAL EDUCATION

7.	Dental School	
8.	Location	Date Graduated (mo, day, yr)
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 _____	
10.	Internship, Residency or Post-Graduate Training	Date Completed (mo, day, yr)
11.	Other College or University Education (include dates and degrees earned)	

EXAMINATIONS

Month	Day	Year

12. NATIONAL BOARD EXAMINATION *(if applicable)* - Date Completed
(Attach a notarized copy of National Board certificate or card) ……

13. CLINICAL EXAMINATION FOR LICENSURE *(if applicable)* - Date Completed
(Attach a notarized copy of proof of passing the examination) ……

14. MINNESOTA JURISPRUDENCE EXAMINATION - Date Completed
(Attach an original or a notarized copy of proof of passing the Exam. Examination on the Rules of the Minnesota Dental Practice Act must be passed within 5 years prior to application.)

15. Other national, regional, state, country 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. _____

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)

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

Title _____

DISCLOSURE QUESTIONS YES NO

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)* ❑ ❑

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)* ❑ ❑

20. Have you ever been convicted of a felony or gross misdemeanor? *(If so, attach a statement giving full details)* ❑ ❑

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)* ❑ ❑

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? ❑ ❑

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 OTHER DENTISTS WITH WHOM YOU ARE ACQUAINTED (for at least one year) BUT NOT RELATED TO AND NOT INCLUDED ELSEWHERE ON THIS APPLICATION (2 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 as a faculty dentist in Minnesota.

Name _____Address _____

City _____ State _____ Zip _____

Dental school graduated from _____ on _____/_____/_____

Licensed in (state, province, country) _____License Number _____

Phone 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 as a faculty dentist in Minnesota.

Name _____Address _____

City _____ State _____ Zip _____

Dental school graduated from _____ on _____/_____/_____

Licensed in (state, province, country) _____ License Number _____

Phone number (_____)_____

_____

(Original Signature) *(Date)*

24. **REFERENCES – Personal Acquaintances**

Name and addresses of three (3) persons with whom you are personally acquainted but not related to and not included elsewhere on this application.

Name _____ Occupation _____

Address _____City _____

State _____ Zip _____ Phone (_____)__ _____

Name _____ Occupation _____

Address _____City _____

State _____ Zip _____ Phone (_____)__ _____

Name _____ Occupation _____

Address _____City _____

State _____ Zip _____ Phone (_____)__ _____

25. **REFERENCES - Dentists**

Names and addresses of three (3) dentists with whom you are personally acquainted but not related to and not included elsewhere on this application.

Name _____ Occupation _____

Address _____City _____

State _____ Zip _____ Phone (_____)__ _____

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 a license as a faculty dentist in Minnesota, 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 or stamp above)
Notary Public Signature

*****IMPORTANT – PLEASE READ*****

A) Pursuant to Minnesota Statute 150A.06, subdivision 1a and Minnesota Rule 3100.1150, subpart c, you are required to submit a letter with this application from the Dean or Program Director of the accredited dental, dental hygiene, or dental assisting program in which you work. The letter must provide the following information:

(1) the applicant's full name;
(2) the applicant's social security number;
(3) the applicant's home and work address;
(4) a letter from the Dean/ Program Director that the applicant is a member of the faculty and practices dentistry within the school or its affiliated teaching facilities;
(5) the dates of the applicant's employment by the school of dentistry;
(6) a statement that the applicant has been notified of the need to be licensed by the board as a limited faculty dentist; and
(7) a statement that the information provided is accurate and complete.
(8) **a photocopy of current BLS Healthcare provider CPR certification.**

B) With a limited faculty dentist license you will not be allowed to have an intramural or private practice. (If you wish to practice in a private or intramural setting, please contact the Board office to discuss your licensure options.) Licensees who disregard this requirement may be disciplined or have their license revoked.

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 on our website under Forms http://mn.gov/boards/dentistry/forms/ :**

_ PLEASE DO NOT WRITE BELOW _

____ DIP ____	____ PHOTO ____	____ DEAN LETTER ____
____ AFFID. ____	____ TESTI. ____	____ REFERENCES ____
____ JURIS ____	____ FEE ____	____ OTHER ____

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