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 LICENSE TO PRACTICE DENTISTRY AS A RESIDENT DENTIST

(Pursuant to Minnesota Rule 3100.1160, subpart 1)

NON REFUNDABLE FEE DUE - $87.00

(Application Fee $55.00, 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 residency program and address (**please attach letter from program director stating acceptance and completion date).**		City, State, Zip
3.			
4.	Mailing Address (street)		City, State, Zip/Country
5.	Telephone (include area code)		Email Address (mandatory)
6.	Sex ❑ Male ❑ Female	Birthdate	Social Security Number _____--_____--_____
	Other name(s) by which you are or have been known and reasons for change:		

DENTAL EDUCATION

7.	Dental School	
8.	Location	Date Graduated (month, day, year)
9.	Degree (attach a notarized copy of diploma) ❑ D.D.S. ❑ D.M.D. ❑ Other (specify) _____	
10.	Internship, Residency or Post-Graduate Training	Date Completed (month, day, year)
11.	Other College or University Education (include dates and degrees/certificates 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 notarized copy of proof of passing the Exam. The Jurisprudence examination 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/country of _____

on the _____ day of _____, _____, and that this license is: ❑ active ❑ terminated _____.
(month) (year) (date)

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

	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, gross misdemeanor or misdemeanor? *(If so, attach a statement giving full details)*	❑	❑
21. Are there any unsatisfied judgments against you which result 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 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 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 resident 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 resident 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 resident dentist license 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 ____

____
Notary Public Signature

_ _

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 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.)*
- Your check or money order should be in U.S. funds payable to the Minnesota Board of Dentistry. Pursuant to Minnesota Statute § 604.113, there will be a $20 service charge on all checks not honored by your bank.
- Please attached a copy of your current AHA Healthcare Provider, or ARC Professional Rescuer w/ AED CPR certification.
- 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*

Please use this space to complete answers only when there is insufficient space following the items on the preceding pages.

QUESTION NUMBER ______________________________ANSWER__________________________________

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 https://mn.gov/boards/dentistry/forms/**

____
Signature (Required for this section only)

_ PLEASE DO NOT WRITE BELOW _

____ DIP ____ ____ PHOTO ____ ____ LOG
____ EXAM ____ ____ OTHER ____ ____ COMP ENT
____ JURIS ____ ____ FEE ____ ____ CERT