

Please read the following information and, **do not submit applications until they are complete, and include all supporting documentation.**

Application:

- Print single-sided and do not staple any documents in your application.
- Attach additional sheets of paper as needed. Added sheets should specifically reference the application.
- If you send documentation separately from your application, place a post-it note on the first page of your application indicating that the required documentation is “on file at the Board”.

Once received by the Board, all applications go through a two-person review. If the CBC Unit has delivered your criminal background check results to the Board, the application is added to the queue to be processed. Applications in the queue are processed in the order in which they were date-stamped. If after the two-person review the criminal background check results have not been received, the application will be stored until the criminal background check is brought to the Board. Incomplete applications will be returned to the applicant.

Application Payment:

- Cash/Money Order payment NOT accepted.
- Check (personal/cashiers) accepted for the full amount listed on the application.
- If online payment was submitted via pre-application, additional payment is not required.

Criminal background check:

- Applications for licensure are not processed until the applicant’s criminal background check results have been delivered to the Board of Dentistry.

Background:

- Email addresses are required for future correspondences.
- If you have legally changed your name, your application also requires a copy of the legal document that changed your name. The copy does not need to be notarized and certified.

Disclosure Questions:

- If you have had a criminal conviction, please attach:
 - A personal statement detailing the events leading up to and following the conviction,
 - A copy of the court sentencing order from the designated county clerk or courthouse, and
 - A copy of the arresting officer’s report, if available.

Attestation of Applicant:

- All applicants must complete the Attestation of Applicant.
- Signatures on the Attestation of Applicant must be original. Copies are not accepted.

Minnesota Government Data Practice Act Notice:

This notice is given pursuant to Minnesota Statutes §13.04, subdivision 2, and §13.41, subdivision 2. Licensure in Minnesota requires all information requested in this application. The required documentation will determine if you meet statutory and rule prerequisites for licensure in Minnesota. Omissions or inaccuracies may lead to the rejection of your application. Except for your name and address, the contents of your application are private. Once you are licensed, that information becomes public. "Private" is defined by law as information accessible only to 1) you, 2) Board of Dentistry staff, 3) individuals designated by you, 4) individuals required to verify the application contents, and 5) the Board's legal staff. If your application becomes contested and results in litigation or a case hearing, the application materials may become available to the Minnesota Office of Administrative Hearings, designated courts, and individuals associated with any proceedings. The information will then become public.

Americans with Disabilities Act:

The Minnesota Board of Dentistry complies with the Americans with Disabilities Act (ADA). The ADA asserts that qualified individuals with disabilities cannot be excluded from participating in programs, services, or activities offered by the Board of Dentistry. For more information, contact the Board of Dentistry.

Board use ONLY
Appl. # _____
License # _____
Issue Date _____

Licensure to Practice as a Volunteer
Please select your license type:

___ Assistant ___ Dentist ___ Hygienist ___ Dental Therapist

1. Background			
Legal First Name	Legal Middle Name	Legal Last Name	Today's Date (MM/DD/YYYY)
Mailing Address		Apt/Unit Number	City, State, Zip Code
Telephone (including area code)		Email Address (required)	
Primary Practice Name/Address (required if employed)		Unit/Suite Number	City, State, Zip Code
Practice Telephone (including area code)		Personal Practice Email Address	
Gender ___ M ___ F ___ X	Birthdate (MM/DD/YYYY)	U.S. Social Security Number (XXX-XX-XXXX)	
Other legal names previously used, and reason for name change <i>(if exam scores reflect former name, include legal proof of name change)</i>			

2. Dental Education	
<p style="text-align: right; color: red;">Your school must send proof directly to Board</p> <p style="text-align: center;">The school must email official e-transcript directly to dental.board@state.mn.us</p>	
Name of Dental School or Program	Degree ___ AAS ___ AS ___ BS ___ DDS ___ DMD ___ Other
City, State	Date of Graduation (MM/DD/YYYY)

3. Volunteer Practice	
Name of public health clinic or sponsoring organization	
Clinic or Event Address	City, State, Zip
Telephone (including area code)	Name of clinic coordinator or director

4. Professional Background	
List each state and/or country in which you are or have been licensed as a dental professional. Include license number(s)	
Licensure verification from each jurisdiction listed is required. Licensing authorities that do not have public online verification must send original license verifications directly to the Board at dental.board@state.mn.us	
List each dental practice <u>where you currently practice out of state</u> . Use a separate sheet if necessary.	
Name of practice (primary)	Practice address
Your duties	Supervisor's name
Dates of employment and total HOURS worked	
Name of practice (secondary)	Practice address
Your duties	Supervisor's name
Dates of employment and total HOURS worked	

5. Questionnaire	
I understand that I will receive no compensation as a volunteer.	___ Yes ___ No
I understand that I may not practice until my volunteer license has been granted by the Board of Dentistry.	___ Yes ___ No
I understand that the volunteer license only allows me to practice at the location listed in #3 of this application for 10 days out of this current calendar year.	___ Yes ___ No
I understand that, once licensed, I am subject to Minnesota laws and rules as well as the regulatory authority of the Minnesota Board of Dentistry.	___ Yes ___ No
I understand that it is my responsibility to notify the Board of any changes in the status of my sponsoring clinic or organization.	___ Yes ___ No
I understand that I must immediately notify the Board if my out-of-state license is terminated or disciplined or if I no longer actively practice out-of-state for any reason.	___ Yes ___ No
I have included a letter from the clinic listed in #3. The letter includes 1) a statement, program description, or other indication that the clinic provides dental care to patients who have trouble accessing dental care and 2) that the clinic is a tax-exempt, non-profit organization under chapter 501(c)(3) of the IRS code of 1986.	___ Yes ___ No

6. Disclosure Questions	
Are you under investigation or are you the subject of any pending or past disciplinary action or have you ever been refused a dental professional license or any other occupational license in any state, territory or country? If so, attach a statement describing the reason for disciplinary action, the dates, the disposition, and contact information for the licensing authority.	___ Yes ___ No
Are there any criminal charges pending against you? If so, attach a statement detailing the reasons for the charges, the dates, the name and location of the court, and the case number.	___ Yes ___ No
Have you ever been convicted of a felony, gross misdemeanor, or a misdemeanor? If so, attach a statement detailing the reasons for the charges, the dates, the name of the court, and the case.	___ Yes ___ No
Are there any unsatisfied judgments against you that resulted from practicing dentistry? If so, attach a statement detailing the nature of the judgment, the dates, and the reasons for non- payment.	___ Yes ___ No
Do you have any diagnosed and/or treated mental, physical, or cognitive condition or illness that could affect your ability to practice with reasonable skill and safety that has not been reported to HPSP?	___ Yes ___ No
Do you have any diagnosed and/or treated substance use disorder that may affect your ability to practice with reasonable skill and safety that has not been reported to HPSP?	___ Yes ___ No

7. Attestation of Applicant

I certify that I am the person referred to in this application for licensure. I understand that including false information or false documentation in this application may result in the penalty of perjury. I understand that falsifying information to attain licensure is a gross misdemeanor and violates the Dental Practice Act. I certify that the entirety of this application and the attached materials are true and correct. I authorize all persons and organizations to release any requested information, files, or records in connection with this application to the Minnesota Board of Dentistry.

Applicant Name (print)

Original Applicant Signature

Date (MM/DD/YYYY)

8. CPR Card

Include a copy of your current CPR certification for healthcare providers.

9. Government Issued I.D.

Include a copy of an official and current U.S. Government Issued I.D. (Examples – Drivers License, State I.D., Passport, Visa)

Board Use ONLY – Staff Comments Below

Rev. 07/25