FLORIDA DEPARTMENT OF HEALTH
BOARD OF DENTISTRY

DENTAL RADIOGRAPHY CERTIFICATION APPLICATION
466.017(7), Florida Statutes Rule 64B5-9.011, Florida Administrative Code

REQUIREMENTS:

1. A **NON-REFUNDABLE fee of $35.00 is required at application**. Please make check or money order payable to the Board of Dentistry and mail to the Department of Health, P. O. Box 6330, Tallahassee, FL 32314-6330. If you need to send additional information that does not include a check or money order, mail it to Department of Health, Board of Dentistry, 4052 Bald Cypress Way, #C08, Tallahassee, FL 32399- 3258.
2. Certification requires three (3) months continuous experience assisting in the exposing of radiographs under the **DIRECT SUPERVISION of a Florida licensed dentist** and successful completion of a Board of Dentistry approved course. The approved course must have been completed within 12 months after the on-the-job training. Attach a copy of the certificate you received from the approved course you attended.

TO BE COMPLETED BY THE DENTAL ASSISTANT SEEKING RADIOGRAPHY CERTIFICATION:
PART I – PROFILE DATA

List your full, legal NAME as it should appear on the Radiography Certificate:

FIRST: MIDDLE: LAST:

Date of Birth:	Primary Telephone: Secondary Phone:
Mailing address:	
Dentist Name: Dentist Telephone:	Dentist Address:

Dates of three (3) months continuous training:

FROM:_____ TO: _____
(Month Day Year) (Month Day Year)

I HEREBY CERTIFY THAT THE ABOVE NAMED DENTAL ASSISTANT HAS BEEN IN MY EMPLOY FOR A MINIMUM OF THREE (3) MONTHS CONTINUOUS SERVICE AND RECEIVED THREE (3) MONTHS OF RADIOGRAPHIC TRAINING.
SIGNATURE OF DENTIST & LICENSE NO. _____

FALSE INFORMATION IN THE APPLICATION PROCESS WILL RESULT IN APPLICATION DENIAL AND MAY RESULT IN CRIMINAL CHARGES AGAINST APPLICANT.

SIGNATURE OF APPLICANT: _____

Email Notification: If you want to be notified of the status of your application by email please check the "Yes" box and write your email address on the line provided below. If you choose this form of notification, you will receive information regarding your application file through email. You will be responsible for checking your email regularly and updating your email address with the Board office. ☐ Yes ☐ No

Email Address: _____
Under Florida law, email addresses are public records. If you do not want your e-mail address released in response to a public records request, do not provide an email address or send electronic mail to our office.

TO BE COMPLETED BY THE DENTAL ASSISTANT SEEKING RADIOGRAPHY CERTIFICATION:
PART II - PERSONAL AND LICENSURE HISTORY

Criminal and Health Care Fraud Questions

IMPORTANT NOTICE: Applicants for licensure, certification or registration and candidates for examination may be excluded from licensure, certification or registration if their felony conviction falls into certain timeframes as established in Section 456.0635(2), Florida Statutes. If you answer YES to any of the following questions, please provide a written explanation for each question including the county and state of each termination or conviction, date of each termination or conviction, and copies of supporting documentation to the address below. Supporting documentation includes court dispositions or agency orders where applicable.

1. Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under Chapter 409, F.S. (relating to social and economic assistance), Chapter 817, F.S. (relating to fraudulent practices), Chapter 893, F.S. (relating to drug abuse prevention and control) or a similar felony offense(s) in another state or jurisdiction? **If "no", skip to #2.** ☐ Yes ☐ No

   a. **If "yes" to 1,** for the felonies of the first or second degree, has it been more than 15 years from the date of the plea, sentence and completion of any subsequent probation? ☐ Yes ☐ No

   b. **If "yes" to 1,** for the felonies of the third degree, has it been more than 10 years from the date of the plea, sentence and completion of any subsequent probation? (This question does not apply to felonies of the third degree under Section 893.13(6)(a), Florida Statutes). ☐ Yes ☐ No

   c. If **"yes" to 1,** for the felonies of the third degree under Section 893.13(6)(a), Florida Statutes, has it been more than 5 years from the date of the plea, sentence and completion of any subsequent probation? ☐ Yes ☐ No

   d. **If "yes" to 1,** have you successfully completed a drug court program that resulted in the plea for the felony offense being withdrawn or the charges dismissed? (If "yes", please provide supporting documentation). ☐ Yes ☐ No

2. Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under 21 U.S.C. ss. 801-970 (relating to controlled substances) or 42 U.S.C. ss. 1395-1396 (relating to public health, welfare, Medicare and Medicaid issues)? **If "no", skip to #3.** ☐ Yes ☐ No

   a. **If "yes" to 2,** has it been more than 15 years before the date of application since the sentence and any subsequent period of probation for such conviction or plea ended? ☐ Yes ☐ No

3. Have you ever been terminated for cause from the Florida Medicaid Program pursuant to Section 409.913, Florida Statutes? **If "no", skip to #4.** ☐ Yes ☐ No

   a. If you have been terminated but reinstated, have you been in good standing with the Florida Medicaid Program for the most recent five years? ☐ Yes ☐ No

4. Have you ever been terminated for cause, pursuant to the appeals procedures established by the state from any other state Medicaid program? **If no, skip to #5.** ☐ Yes ☐ No

   a. Have you been in good standing with a state Medicaid program for the most recent five years? ☐ Yes ☐ No

   b. Did the termination occur at least 20 years prior to the date of this application? ☐ Yes ☐ No

5. Are you currently listed on the United States Department of Health and Human Services Office of Inspector General's List of Excluded Individuals and Entities? ☐ Yes ☐ No

Applicant History – Professional Licensure – If any below questions are answered "YES", you must provide complete details as to state(s), license number(s), dates, and relevant circumstances on attached sheet.

Have you ever been denied the right to take any healthcare license or certification examination in any state? ☐ Yes ☐ No

Have you ever been refused a license to practice a healthcare profession or any other license or the renewal thereof in any state? ☐ Yes ☐ No

Have you ever had a license or a certificate of registration to practice a healthcare profession or any other licensed profession revoked, suspended or otherwise acted against (including probation, fine or reprimand) in a disciplinary proceeding in any state? ☐ Yes ☐ No

PART III- APPLICANT RELEASE

THE FOLLOWING STATEMENT MUST BE COMPLETED:

APPLICANT RELEASE:

I,_____, state that I am the person referred to in the foregoing Dental Radiography Certification application and supporting documentation, that said application and any supporting documentation are true and accurate.

I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past and present), business and professional associates (past and present), and all governmental agencies and instrumentalities (local, state, federal and foreign) to release to the Florida Department of Health any information, files, or records requested by the agency in connection with the processing of this application. I further authorize the Florida Department of Health to release to any organization, individual or group listed above any information which is material to my application.

I understand that it is my responsibility to supplement my application as needed to reflect any material changes in any circumstance or condition stated in the application which might affect the decision of the department and which takes place between the initial filing of the application and the final granting or denial of residency/intern permit.

I have carefully read the instructions and questions in the foregoing application and have answered them completely, without reservations of any kind. Should I furnish any false information in this application, or in any supporting documentation, I acknowledge that such an act constitutes cause for denial, disciplinary action, suspension or revocation of my certification to practice Dental Radiography under Chapter 466, Florida Statutes, Chapter 456, Florida Statutes, and Chapter 64B5, Florida Administrative Code, in the State of Florida.

I hereby affirm that I have received, read and understood Chapter 466, Florida Statutes, Chapter 456, Florida Statutes, and Chapter 64B5, Florida Administrative Code, and acknowledge that I must abide by them.

Signature of applicant _____ Date _____

CONFIDENTIAL AND EXEMPT FROM PUBLIC RECORDS DISCLOSURE*

Name:			**Social Security Number:**
_____			_____
Last	First	Middle	

*Pursuant to 42 U.S.C. § 666(a)(13), the department is required and authorized to collect Social Security Numbers relating to applications for professional licensure. Additionally, section 456.013(1)(a), Florida Statutes, authorizes the collection of Social Security Numbers as part of the general licensing provisions. This information is exempt from public records disclosure.

PART IV - APPLICANT HISTORY – HEALTH

Applicant Health History - If you answer "YES" to any of the following questions, you must submit a current mental health status report from a licensed mental health professional, wherein this professional practitioner opines that you are able to practice with reasonable skill and safety to patients or clients.

In the last 5 years, have you been enrolled in, required to enter into, or participated in any drug or alcohol recovery program or impaired practitioner program for treatment of drug or alcohol abuse that occurred within the past 5 years? ☐ Yes ☐ No

In the last 5 years, have you been admitted or referred to a hospital, facility or impaired practitioner program for treatment of a diagnosed mental disorder or impairment? ☐ Yes ☐ No

During the last 5 years, have you been treated for or had a recurrence of a diagnosed mental disorder that has impaired your ability to practice your profession within the past 5 years? ☐ Yes ☐ No

In the last 5 years, were you admitted or directed into a program for the treatment of a diagnosed substance-related (alcohol/drug) disorder or, if you were previously in such a program, did you suffer a relapse within the last 5 years? ☐ Yes ☐ No

During the last 5 years, have you been treated for or had a recurrence of a diagnosed substance-related (alcohol/drug) disorder that has impaired your ability to practice your profession within the past 5 years? ☐ Yes ☐ No

During the last 5 years, have you been treated for or had a recurrence of a diagnosed physical disorder that has impaired your ability to practice your profession? ☐ Yes ☐ No