FLORIDA
DEPARTMENT OF HEALTH

BOARD OF DENTISTRY

DENTAL LICENSURE APPLICATION

Florida Board of Dentistry
4052 Bald Cypress Way, #C-08
Tallahassee, FL 32399-3258
Phone: (850) 245-4474 Fax: (850) 921-5389
www.FloridasDentistry.gov
Email: info@floridasdentistry.gov

Dental Licensure Application Instructions

Applicants are strongly encouraged to review s. 466.006, F.S. and Rule Chapter 64B5-2, F.A.C. prior to submitting this application.

EXAMINATION REQUIREMENTS:

- Successful completion of the National Board Dental Examination (Part I and II)
- Successful completion of the ADEX Dental Licensing Examination administered in Florida; OR
- Successful completion of the ADEX Dental Licensing Examination in a jurisdiction other than Florida, if the examination was completed after October 1, 2011
- Successful completion of the Florida Laws and Rules Examination

Applicants must apply for the Florida Laws and Rules examination with The Commission on Dental Competency Assessments (CDCA). Please visit www.cdcaexams.org to register.

EDUCATION REQUIREMENTS:

Graduation from a dental school accredited by the American Dental Association Commission on Dental Accreditation or its successor agency; OR

Graduation from a dental school not accredited by the Commission on Dental Accreditation of the American Dental Association and completion of at least 2 consecutive academic years at a full-time supplemental general dentistry program accredited by the American Dental Association Commission on Dental Accreditation. This program must provide didactic and clinical education at the level of a D.D.S. or D.M.D. program accredited by the American Dental Association Commission on Dental Accreditation.

FEES:

Application fee	100.00
Licensure fee	300.00*
Unlicensed Activity fee	5.00
TOTAL FEE	**$405.00**

*Licensure fee is $150 for applicants applying in second year of biennium. All initial licenses expire February 28 of the following even numbered year. Licensure biennium dates are March 1 – February 28 of the even years.

The fee must accompany the application. Please make check or money order payable to the **Department of Health** and mail with application, supporting documentation and credentials to:

DEPARTMENT OF HEALTH
P.O. BOX 6330
TALLAHASSEE, FLORIDA 32314-6330

Any supporting documentation and credentials mailed **separately** from the application should be mailed to:

DEPARTMENT OF HEALTH
BOARD OF DENTISTRY
4052 BALD CYPRESS WAY, BIN #C08
TALLAHASSEE, FLORIDA 32399-3258

REFUNDS

The application fee is non-refundable. Applicants who require board approval will be scheduled for an appearance at the next board meeting.

If an application is received without the fee attached, the application will automatically be returned. A social security number issued by the Federal Government is required for licensure. After completing the application, double check to make sure you have marked all questions as "yes" or "no" or not applicable. Also be sure to sign and date the application. If you answered, "yes" to question(s) 5, 6, 7, and/or 12, please submit all supporting documentation with the application.

CREDENTIALS:

All credentials mailed separately to the Board of Dentistry office should be sent to 4052 Bald Cypress Way, BIN #C08 Tallahassee, Florida 32399-3258.

(1) **National Board Score:** The Board office must receive proof of successful completion of the National Board Dental Examination. The scores must be mailed to our office from The Joint Commission on National Dental Examinations.

(2) **Final Official Transcript:** Dental transcripts shall be sent to the Board of Dentistry by the registrar's office. ALL final transcripts must indicate the matriculation date, graduation date, degree earned, and be embossed with the school seal. We will not accept any transcript that has "issued to student" stamped on the transcript. Any transcript, which does not conform to these standards, shall be deemed unofficial and unacceptable.

(3) **Certification of Licensure**: Please submit certification of licensure from each state in which you hold or have held a dental or dental hygiene license. This certification should state that your license is in good standing; appropriate signatures and embossed seal of the certifying Board are needed for validation.

(4) **CPR Certification:** Each applicant must provide proof of training in cardiopulmonary resuscitation (CPR) at the basic support level, including one-rescuer and two rescuer CPR for adults, children, and infants; the use of an automatic external defibrillator (AED); and the use of ambu-bags. All such training shall be sufficient for and shall result in current certification or recertification by the American Heart Association, the American Red Cross or an entity with equivalent requirements.

(5) **Other:** If you have changed your name in any way or added or deleted part of your name from the time you started your dental education, you must submit a copy of your name change document. If you do not have a name change document filed with the courts, submit a notarized affidavit stating the names are one and the same. Please notify the board office if you have documents being sent to us in another name.

IMPORTANT INFORMATION

Applicants who complete the ADEX examination in a jurisdiction other than Florida may be required to complete additional requirements. Please read s. 466.006, Florida Statutes, Rule 64B5-2.0150, F.A.C., and Rule 64B5-2.0152, F.A.C prior to submitting your application.

Staple two photos in this area. Do not glue or paste.

Dental Licensure Application

PO Box 6330
Tallahassee, FL 32314-6330
Phone: (850) 245-4474
Fax: (850) 921-5389

Please complete this application in its entirety prior to submitting

Do Not Write in this Space For Revenue Receipting Only

Fees must be paid in the form of a cashier's check or money order, made payable to: DOH Florida Board of Dentistry

1. Examination History

Date of ADEX Exam: _____ Location of ADEX Exam: _____

2. Application Profile Data

Name: _____ Date of Birth: _____
Last First Middle MM/DD/YYYY

Mailing Address: (Give the address where mail and your license should be sent)

_____ _____ _____
Street/PO Box Apt. No. City

_____ _____ _____ _____
State Zip Country Primary Telephone

Physical Location: (Required if mailing address is a P.O. Box- This address will be posted on the Department of Health's website.)

_____ _____ _____
Street Apt./Suite No. City

_____ _____ _____ _____
State Zip Country Secondary Telephone

Have you ever changed your name through marriage or through action of a court, or have you ever been known by any other name? ☐ Yes ☐ No
If yes, list name(s) and date(s) of change(s): _____

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.

Equal Opportunity Data: We are required to ask that you furnish information as part of your voluntary compliance with Section 2, Uniform Guidelines on Employee Selection Procedure (1978) 43 CFR 38295 and 38296 (August 25, 1978). This information is gathered for statistical and reporting purposes only and does not in any way affect your candidacy for licensure.

RACE: ☐ White ☐ Black or African American ☐ Asian ☐ American Indian or Alaska Native ☐ Hispanic ☐ Two or More Races

3. Applicant Education and Examination Data

Dental School Attended: _____ City: _____ State: _____

Degree: _____ Date Graduated/Anticipated Graduation: _____

Official transcripts including degree and date of graduation must be sent DIRECTLY from your school to the Board of Dentistry before your application can be deemed complete.

Have you successfully completed the National Board Dental Exam? ☐ Yes ☐ No

If taken under another name, please provide: _____

These results must be sent directly from The Joint Commission on National Dental Examinations to the Florida Board of Dentistry. The contact information is: 211 East Chicago Avenue, Chicago, Illinois 60611, (800) 323-1694.

4. Applicant Licensure Status

Do you now hold or have you ever held a license to practice Dentistry or Dental Hygiene in any state, U.S. territory or foreign country? (List most recent first) ☐ Yes ☐ No

State/Jurisdiction	License No.	If no longer licensed, state why and when

5. Criminal History

Have you ever been convicted of, or entered a plea of guilty, nolo contendere, or no contest to a crime in any jurisdiction other than a minor traffic offense? You must include all misdemeanors and felonies, even if adjudication was withheld by the court so that you would not have a record or conviction. Driving under the influence or driving while impaired is not a minor traffic offense for purposes of this question. ☐ Yes ☐ No

If you answered "Yes" to the question above you are required to send the following items:

☐ **Self Explanation** describing in detail the circumstances surrounding each offense; including dates, city and state, charges and final results.

☐ **Final Dispositions and Arrest Records** for all offenses. The Clerk of the Court in the arresting jurisdiction will provide you with these documents. Unavailability of these documents must come in the form of a letter from the Clerk of the Court.

☐ **Completion of Sentence Documents**. You may obtain documents from the Department of Corrections. The report must include the start date, end date and that the conditions were met.

6. 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

7. 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 a Dentistry or Dental Hygiene examination in any state? ☐ Yes ☐ No

Have you ever been refused a license to practice Dentistry, Dental Hygiene 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 Dentistry, Dental Hygiene 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

Are you now or have you ever been a defendant in civil litigation in which the basis of the complaint against you was in alleged negligence, malpractice or lack of professional competence? ☐ Yes ☐ No

In any jurisdiction, do you have a pending complaint against your professional conduct or competence as a Dentist or Dental Hygienist? ☐ Yes ☐ No

8. Statement of Financial Responsibility

☐ I have obtained and will maintain professional liability coverage in an amount of not less than $100,000, with a minimum annual aggregate of not less than $300,000 from an authorized insurer as defined under Section 624.09, F.S., from a surplus lines insurer as defined under Section 626.914(2), F.S., from a risk retention group as defined under Section 627.942, F.S., from the Joint Underwriting Association established under Section 627.351(4), F.S., or through a plan of self-insurance as provided in Section 627.357, F.S

☐ I have obtained and will maintain an unexpired, irrevocable letter of credit, established pursuant to Chapter 675, F.S., in an amount of not less than $100,000 per claim, with a minimum aggregate availability of credit not less than $300,000.

☐ I am exempt from demonstrating financial responsibility because I practice exclusively as an officer, employee or agent of the federal government, or of the state or its agencies or subdivisions.

☐ I am exempt from demonstrating financial responsibility because I practice only in conjunction with my teaching duties at an accredited school or in its main teaching hospitals.

☐ I am exempt from demonstrating financial responsibility because I do not practice in the State of Florida.

☐ I am exempt from demonstrating financial responsibility because I have no malpractice exposure in the State of Florida.

9. Drug Enforcement Administration Registration

Are you registered with the DEA to prescribe controlled substances? ☐ Yes ☐ No

If yes, please provide your DEA number: _____

10. Oath/Verification of Document

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, or foreign) to release to the Florida Department of Health my information files or records requested by the department in connection with the processing of this application. I further authorize the Florida Department of Health to release to the organizations, individuals and groups 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 licensure. I understand that the application fee is non-refundable.

Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for the denial, suspension, or revocation of any license to practice in the State of Florida the profession for which I am applying.

Under penalties of perjury, I declare that I have read the foregoing Dental Licensure Application and that the facts stated in it are true.

Applicant Signature _____ Date _____

11. Remarks

This section is for any additional information you would like to give us. Please refer to the section number (within the application) you are referring to. An example would be: #2, Applicant Profile Data.

CONFIDENTIAL AND EXEMPT FROM PUBLIC RECORDS DISCLOSURE*

12. Name:			Social Security Number:
Last	First	Middle	

*Pursuant to 466(a)(13), 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.

13. 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

CERTIFICATE OF LICENSURE

Instructions: For your convenience, you may tear out this page and send it to the Secretary of the Board in the state(s) where you hold or have held a license. However, only certificates bearing the ORIGINAL signature of certifying authorities will be accepted by the Florida Board of Dentistry.

CERTIFICATION OF SECRETARY OF BOARD OF THE STATE
IN WHICH APPLICANT HOLDS OR HAS HELD A
DENTAL/DENTAL HYGIENE LICENSE
(Required of all previously licensed candidates)

I, _____

Secretary of _____
Official name of Board

Hereby certify that _____was granted State Certificate No. _____

to practice ☐ Dentistry ☐ Dental Hygiene in the state of _____

on the _____ day of _____, 20_____, on the basis of _____

- I hereby certify that the said applicant is in good standing with this board and there have not been any disciplinary procedures against, or pending on, said applicant.

(SEAL)
NOT VALID WITHOUT
STATE SEAL

_____
Secretary

- If disciplinary action has been taken, please indicate, and submit supporting information.