



## Application for Health Access Dental License

**Board of Dentistry**  
P.O. Box 6330  
Tallahassee, FL 32314-6330  
**Website:** [floridasdentistry.gov](http://floridasdentistry.gov)  
**Email:** [info@floridasdentistry.gov](mailto:info@floridasdentistry.gov)  
**Phone:** (850) 245-4474  
**Fax:** (850) 921-5389



**Are you an active duty member of the United States Armed Services?**

**Are you a veteran of the United States Armed Services?**

**Are you the spouse of a veteran of the United States Armed Services?**

**Are you the spouse of an active member of the United States Armed Services?**

If you answered "Yes" to any of these questions, you may qualify for a reduction in your application fees. You can find information about the Florida Department of Health's commitment to serving members and veterans of the United States Armed Forces and their families online at <http://www.flhealthsource.gov/valor>

# Important Information on Health Access Dental Licensure

**"Health access setting"** means a program or an institution of the Department of Children and Family Services, the Department of Health, the Department of Juvenile Justice, a nonprofit community health center, a Head Start center, a federally qualified health center or look-alike as defined by federal law, a school-based prevention program, a clinic operated by an accredited college of dentistry, or an accredited dental hygiene program in this state if such community service program or institution immediately reports to the Board of Dentistry all violations of section (s.) 466.027, s. 466.028, Florida Statutes (F.S.), or other practice act or standard of care violations related to the actions or inactions of a dentist, dental hygienist, or dental assistant engaged in the delivery of dental care in such setting. Refer to s. 466.003(14), F.S.

## **An applicant is ineligible for this license if they:**

- Have been convicted or pled nolo contendere to, regardless of adjudication, any felony or misdemeanor related to the practice of a health care profession; or
- Have had a license revoked from any U.S. state, the District of Columbia, or a U.S. territory; or
- Have failed the examination specified in s. 466.006, F.S., unless re-examined pursuant to s. 466.006, F.S., and received a license to practice dentistry in this state; or
- Have been reported to the National Practitioner Data Bank, unless successfully appealed to have their name removed from the data bank.



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Do Not Write in this Space  
For Revenue Receiving Only

Applicants are encouraged to review section (s.) 466.0067, Florida Statutes (F.S.), prior to completing your application.

<p><b>Health Access Dental License</b></p> <p style="text-align: right;"><b>\$405.00 (even year)</b> <b>\$255.00 (odd year)</b></p> <p>All initial licenses expire February 28 of the next even numbered year following the date of issuance.</p>	<p><b>Total fee includes the following:</b></p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="padding: 2px;">Application Fee</td> <td style="text-align: right; padding: 2px;">\$100.00</td> </tr> <tr> <td style="padding: 2px;">Initial Licensure Fee (even year)</td> <td style="text-align: right; padding: 2px;">\$300.00</td> </tr> <tr> <td style="padding: 2px;">Initial Licensure Fee (odd year)</td> <td style="text-align: right; padding: 2px;">\$150.00</td> </tr> <tr> <td style="padding: 2px;">Unlicensed Activity Fee</td> <td style="text-align: right; padding: 2px;">\$5.00</td> </tr> </table>	Application Fee	\$100.00	Initial Licensure Fee (even year)	\$300.00	Initial Licensure Fee (odd year)	\$150.00	Unlicensed Activity Fee	\$5.00
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Initial Licensure Fee (even year)	\$300.00								
Initial Licensure Fee (odd year)	\$150.00								
Unlicensed Activity Fee	\$5.00								

Fees must be paid in the form of a cashier's check or money order, made payable to the Department of Health. An applicant who is denied licensure or withdraws their application is entitled to a \$305.00 (even year) or \$155.00 (odd year) (Initial Licensure Fee and Unlicensed Activity Fee) refund. Requests to withdraw or for a refund must be made in writing. Fees are refundable for up to three years from the date of receipt.

## 1. PERSONAL INFORMATION

**Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_  
                             Last/Surname                            First                            Middle                                                                                                    MM/DD/YYYY

**Mailing Address:** (The address where mail and your license should be sent)

\_\_\_\_\_  
 Street/P.O. Box                                                                                                                            Apt. No.    City

\_\_\_\_\_  
 State                                            ZIP                            Country                                            Home/Cell Telephone (Input without dashes)

**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. No.    City

\_\_\_\_\_  
 State                                            ZIP                            Country                                            Work/Cell Telephone (Input without dashes)

**EQUAL OPPORTUNITY DATA:**

We are required to ask that you furnish the following information as part of your voluntary compliance with 41 CFR Part 60-3-Uniform Guidelines on Employee Selection Procedure (1978); 43 FR 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.

Gender:    Male                      Race:    Native Hawaiian or Pacific Islander                      Hispanic or Latino                      White  
               Female                      American Indian or Alaska Native                      Black or African American                      Asian  
                                             Two or More Races

**Email Notification:** To be notified of the status of your application by email, check the "Yes" box and fill in your email address on the line provided. If you choose to be notified via 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 email address released in response to a public records request, do not provide an email address or send electronic mail to our office. Instead contact the office by phone or in writing.



2. SOCIAL SECURITY DISCLOSURE

**This information is exempt from public records disclosure.**

**Last Name:** \_\_\_\_\_

**First Name:** \_\_\_\_\_

**Middle Name:** \_\_\_\_\_

**Social Security Number:** \_\_\_\_\_  
(Input without dashes)

Pursuant to Title 42 United States Code § 666(a)(13), the department is required and authorized to collect Social Security numbers relating to applications for professional licensure. Additionally, s. 456.013(1)(a), F.S. authorizes the collection of Social Security numbers as part of the general licensing provisions.

Name: \_\_\_\_\_

### 3. APPLICANT BACKGROUND

- A. 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):

\_\_\_\_\_

- B. 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

- C. List all dental related licenses (active, inactive, or lapsed), starting with the most recent.

License Type	License #	State	Original Date Issued (MM/DD/YYYY)	Expiration Date (MM/DD/YYYY)	Status of License

- D. List all health-related licenses (active, inactive or lapsed), other than the license(s) listed above.

License Type	License #	State/Country	Original Date Issued (MM/DD/YYYY)	Expiration Date (MM/DD/YYYY)	Status of License

**Submit a License Verification form to ALL state(s) of licensure.** License verifications must be received directly from the licensing authority regardless of the status of the license. **A copy of your license will not be accepted in lieu of official verification from the licensing agency.** If the state has an online verification including **disciplinary actions**, the board office will accept the online verification.

- E. Have you been engaged in the active, clinical practice of dentistry providing direct patient care for 5 years immediately preceding the date of application, or if you graduated from an accredited dental school within the preceding 5 years, have you been engaged in continuous clinical practice providing direct patient care since graduation?    Yes    No

**Submit documentation verifying proof of continuous practice.**

- F. Are you registered with the Drug Enforcement Administration (DEA) to prescribe controlled substances?    Yes    No

If "Yes," provide your DEA number: \_\_\_\_\_

**Submit all supporting documentation not included with the application to the board office at:**

**Board of Dentistry**  
4052 Bald Cypress Way Bin C-04  
Tallahassee, FL 32399-3258

Name: \_\_\_\_\_

#### 4. EDUCATION HISTORY

A. List the dental school(s) you attended.

School Name/Address	Graduation Date (MM/DD/YYYY)	Degree Awarded

**All applicants must have an official transcript forwarded directly to the board office from a dental school accredited by the Commission on Dental Accreditation or its successor agency. Transcripts must indicate the matriculation date, graduation date, degree earned, and be embossed with the school seal. Diplomas and student copies are not acceptable.**

B. Have you completed the required continuing education courses or equivalent for dentists licensed under s. 466.006, F.S. for the last full reporting biennium, as detailed in Rule 64B5-12.013, Florida Administrative Code?  
Yes      No

**Submit documentation verifying proof of completion.**

C. Have you received training and hold current certification from the American Heart Association, the American Red Cross, or other entity with equivalent requirements 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?    Yes      No

American Heart Association	Certification #:
American Red Cross	Issue Date (MM/DD/YYYY):
Other: _____	Expiration Date (MM/DD/YYYY):

D. Have you successfully completed the Florida Laws and Rules examination provided by the Commission on Dental Competency Assessment (CDCA)?      Yes      No

If "No," visit [www.cdcaexams.org](http://www.cdcaexams.org) to register.

#### 5. EXAMINATION HISTORY

A. Have you successfully completed the National Board of Dental Examiners Examination?      Yes      No

B. Did you take the exam under a name other than the one provided in the "Personal Information" section?  
Yes      No

If "Yes," provide the name: \_\_\_\_\_

**All applicants must have National Board of Dental Examiners Examination scores sent directly to the board office from The Joint Commission on National Dental Examination (JCNDE). The JCNDE may be reached at (800) 440-2811.**

C. Have you passed a state or regional clinical dental licensing examination that the board has determined effectively measures applicants' ability to practice safely?      Yes      No

**All applicants must have proof of completion sent directly to the board office from the dental licensing examination agency.**



Name: \_\_\_\_\_

**This information is exempt from public records disclosure.**

**6. HEALTH HISTORY**

**Physical and Mental Health Disorders Impacting Ability to Practice**

- A. During the last two years, have you been treated for or had a recurrence of a diagnosed physical or mental disorder that impaired or would impair your ability to practice?    Yes    No
- B. In the last two years, have you been admitted or referred to a hospital, facility or impaired practitioner program for treatment of a diagnosed mental or physical disorder that impaired your ability to practice?  
Yes    No

**Substance-Related Disorders Impacting Ability to Practice**

- C. During the last five years, have you been treated for or had a recurrence of a diagnosed substance-related (alcohol or drug) disorder that impaired or would impair your ability to practice?    Yes    No
- D. During the last five years, were you admitted or directed into a program for the treatment of a diagnosed substance-related (alcohol or drug) disorder or, if you were previously in such a program, did you suffer a relapse?    Yes    No
- E. During the last five years, have you been enrolled in, required to enter, or participated in any substance-related (alcohol or drug) recovery program or impaired practitioner program for treatment of drug or alcohol abuse?    Yes    No

**If a "Yes" response was provided to any of the questions in this section, provide the following documents directly to the board office:**

**A letter from a Licensed Health Care Practitioner, who is qualified by skill and training to address the condition identified, which explains the impact the condition may have on the ability to practice the profession with reasonable skill and safety. The letter must specify that the applicant is safe to practice the profession without restrictions or specifically indicate the restrictions that are necessary. Documentation provided must be dated within one year of the application date.**

**A written self-explanation, identifying the medical condition(s) or occurrence(s); and current status**



Name: \_\_\_\_\_

**7. DISCIPLINE HISTORY**

- A. Have you ever been denied the right to take a dentistry or dental hygiene examination in any state?  
Yes      No
- B. 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
- C. Have you ever had a license or a certificate to practice any licensed profession revoked, suspended, or otherwise acted against (including probation, fine or reprimand) in a disciplinary proceeding in any state?  
Yes      No
- D. Are you now or have you ever been a defendant in civil litigation in which the basis of the complaint against you was alleged negligence, malpractice, or lack of professional competence?      Yes      No
- E. Do you have a pending complaint in any jurisdiction against your professional conduct or competence as a dentist or dental hygienist?      Yes      No

**If you responded "Yes" to any of the questions in this section, complete the following:**

Name of Agency	State	Action Date (MM/DD/YYYY)	Final Action	Under Appeal?
				Y   N
				Y   N
				Y   N
				Y   N

**If you responded "Yes" to any of the questions in this section, you must provide the following:**

**A written self-explanation**, describing in detail the circumstances surrounding the disciplinary action.

A copy of the **Administrative Complaint and Final Order**.

**8. CRIMINAL HISTORY**

Have you ever been convicted of, or entered a plea of guilty, nolo contendere, or no contest to any crime in any jurisdiction other than a minor traffic offense? You must include all misdemeanors and felonies, even if adjudication was withheld. Pursuant to s. 943.0585(6)(b), F.S., and s. 943.059(6)(b), F.S., an applicant seeking to be licensed by the Department of Health must disclose expunged and sealed criminal history records.

Reckless driving, driving while license suspended or revoked (DWSLR), driving under the influence (DUI) or driving while impaired (DWI) are not minor traffic offenses for purposes of this question.      Yes      No

**If you responded "Yes," complete the following:**

Offense	Jurisdiction	Date (MM/DD/YYYY)	Final Disposition	Under Appeal?
				Y   N
				Y   N
				Y   N

**If you responded "Yes" in this section, you must provide the following:**

**A written 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.

Name: \_\_\_\_\_

## 9. CRIMINAL AND MEDICAID/MEDICARE 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 convictions fall into certain timeframes as established in s. 456.0635(2), F.S.

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

**If you responded "No" to the question above, skip to question 2.**

- 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 ten years from the date of the plea, sentence, and completion of subsequent probation (this question does not apply to felonies of the third degree under s. 893.13(6)(a), F.S.)?      Yes      No
  - c. If "Yes" to 1, for the felonies of the third degree under s. 893.13(6)(a), F.S., has it been more than five 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," provide supporting documentation)?      Yes      No
2. Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, to 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)?      Yes      No

**If you responded "No" to the question above, skip to question 3.**

- 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 s. 409.913, F.S.?      Yes      No

**If you responded "No" to the question above, skip to question 4.**

- 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?      Yes      No

**If you responded "No" to the question above, skip to question 5.**

- a. Have you been in good standing with a state Medicaid program for the most recent five years?      Yes      No
- b. Did termination occur at least 20 years before the date of this application?      Yes      No



Name: \_\_\_\_\_

5. Are you currently listed on the United States Department of Health and Human Services' Office of the Inspector General's List of Excluded Individuals and Entities (LEIE)?                      Yes                      No
- a. If you responded "Yes" to the question above, are you listed because you defaulted or are delinquent on a student loan?                      Yes                      No
- b. If you responded "Yes" to question 5.a., is the student loan default or delinquency the only reason you are listed on the LEIE?                      Yes                      No

**If you responded "Yes" to any of the questions in this section, you must provide the following:**

**A written self-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.

**Supporting documentation** including court dispositions or agency orders where applicable.

**Documents for the preceding sections must be mailed to:**

**Board of Dentistry**  
4052 Bald Cypress Way Bin C-04  
Tallahassee, FL 32399-3258

#### 10. ADDITIONAL REQUIREMENTS

**National Practitioner Data Bank (NPDB) Self-Query- All applicants** are required to complete a self-query to the NPDB and upon receipt of the report, provide the board office with a copy. A fee is charged by the NPDB to provide the self-query. You can contact NPDB at <http://www.npdb.hrsa.gov/> or by telephone at (800) 767-6732.

#### 11. APPLICANT RELEASE

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 license granted by completion of this application is for work in health access settings only.

I understand that whoever knowingly makes a false statement in writing with the intent to mislead a public servant in the performance of his or her official duty shall be guilty of a misdemeanor of the second degree pursuant to s. 837.06, F.S.

Applicant Signature \_\_\_\_\_ Date \_\_\_\_\_  
MM/DD/YYYY



Online verifications submitted by the applicant are acceptable if they are current and show disciplinary history status. Complete verifications must be mailed directly from the licensing agency to:

**Board of Dentistry**  
4052 Bald Cypress Way Bin C-04  
Tallahassee, FL 32399-3258



## Board of Dentistry License Verification Request

**Part I: To be completed by applicant** (Florida requires verification of all your current and previously held licenses.)

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Name original license was issued under: \_\_\_\_\_

License Number: \_\_\_\_\_ State: \_\_\_\_\_

*I hereby authorize release of any information regarding my licensure status to the Florida Board of Dentistry.*

Applicant Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
MM/DD/YYYY

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## Part II: To be completed by state licensing agency

All verifications must be in English and include the following criteria:

- \* Typed on an official state form or letterhead
- \* Include an official board seal
- \* Signature and title of state board official

The following information must be included in all verifications:

- \* Licensee name
- \* License number
- \* State or jurisdiction of licensure
- \* Licensure status
- \* Is license in good standing?
- \* Date of issuance/expiration
- \* Licensure method (examination or reciprocity/endorsement)
- \* Has this license ever been encumbered (denied, revoked, suspended, surrendered, limited, placed on probation)?
- \* If this license has ever been encumbered, please provide certified copies of documentation regarding the action with the completed license verification.