APPLICATION FOR LIMITED LICENSURE
DENTIST/DENTAL HYGIENIST

Statute and Rule References:
-Section 456.015, Florida Statutes
-Rule 64B5- 7.007, Florida Administrative Code

General Requirements and Information
The following criteria MUST be met in order to obtain dentist/dental hygienist limited licensure in Florida:
-The applicant has retired or intends to retire from the practice of dentistry/dental hygiene and intends to practice only pursuant to the restrictions of the limited license; AND
- The applicant was licensed to practice dentistry/dental hygiene in any jurisdiction in the United States for at least 10 years.

The limited licensee can practice only in the employ of public agencies or non-profit agencies or institutions which meet the requirements of s. 501(c)(3) of the Internal Revenue Code, are permitted under rule 64B5-7.006 and which provide professional liability coverage for acts or omissions of the limited licensee. Limited licensees may provide services only to the indigent or critical need populations within the state.

Continuing Education Requirement:
Pursuant to Rule 64B5-7.007(1)(d), F.A.C, the board shall require each limited licensee to complete continuing education requirements of active licensees.

Dentists: 30 continuing education hours to include a 2 hour course in the prevention of medical errors each biennium. A course in HIV/AIDS is required no later than the first renewal and a 2 hour course in domestic violence is required every third biennium. In addition to the 30 continuing education hours, re-certification in CPR at the basic life support level and as defined in Rule 64B5 -12.020, FAC is required.

Dental Hygienists: 24 continuing education hours to include 2 hour course in the prevention of medical errors each biennium. A course in HIV/AIDS is required no later than the first renewal and a 2 hour course in domestic violence is required every third biennium. In addition to the 24 continuing education hours, re-certification in CPR at the basic life support level and as defined in Rule 64B5-12.020, FAC is required.

MAILING ADDRESS
The original application and fee should be mailed to the following address**: Department of Health, Post Office Box 6330, Tallahassee, FL 32314-6330.** *Make checks or money orders payable to **DOH-Board of Dentistry**.*

Applications that do not include a fee and/or supporting documents should be mailed to Department of Health, Board of Dentistry, 4052 Bald Cypress Way, Bin #C08, Tallahassee FL 32399-3258.

REQUIRED DOCUMENTATION INCLUDES
-Proof of completion of a minimum 2 hour course in the Prevention of Medical Errors from a Florida

Board of Dentistry approved provider
-Proof of current CPR certification
-Verifications of licensure MUST be sent directly to the board office from the respective agency.
-Proof of graduation from dental school

PLEASE TYPE OR PRINT LEGIBLY ALL INFORMATION.

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APPLICATION FOR DENTIST/DENTAL HYGIENIST LIMITED LICENSURE

PART I- PROFILE DATA FORM

APPLICATION METHOD: Please check the box applicable to your proposed practice setting.

☐ *Non-Remunerated* (Volunteer - not paid for services). Must submit Fee Waiver Affidavit.

☐ *Remunerated* (Paid employee) **Total due: $305.00 – Dentist $105.00 – Dental Hygienist**

List your full, legal NAME as it should appear on LIMITED license (no nicknames or shortened versions):

FIRST: MIDDLE: LAST:

Have you ever changed your name through marriage or action of a court, or have you been known by any other name? *If "YES", give the name(s) and date(s) of changes below:* ☐YES ☐NO

Social Security Number - Required (Enter on separate page provided in application)	City/State/Country of Birth:	Date of Birth (m/d/yr)

MAILING Address (street address, city, state, ZIP):

Primary Telephone Number: ( )	Business Telephone Number: ( )

Name of Dental/Dental Hygiene School you attended:	Type of Degree:	Date Graduated:
____________________ School Name (attach copy of diploma) ____________________ City State	☐ D.D.S. ☐ D.M.D. ☐ A.S. Other__________	

PART II - LICENSURE DATA

Please list below all licensure/certifications to practice dentistry/dental hygiene or any health-related profession in any jurisdiction in the U.S. territory, including, Florida, or foreign country that you current hold or have ever held, regardless of status.

State	License Title	License Number	Original Issue Date	Expiration Date	

PART III - PRACTICE AFFIRMATION AND HISTORY

Do you affirm that you have practiced dentistry/dental hygiene as a licensed dentist/dental hygienist for at least ten years in the United States?	YES NO
Do you affirm that you have retired or intend to retire from the practice of dentistry/dental hygiene? *Please give the date (m/d/yr) of actual or intended retirement:*	YES NO
Do you affirm that you will practice only as specified in Rule 64B5-7.007, Florida Administrative Code, if granted a limited license in Florida?	YES NO

List Place of Practice in Florida. The director of the agency or institution must submit a letter of intention to employ. Section 456.015, Florida Statutes, requires that within 30 days of any change of employment, the department must be notified of the new address and place of employment.

Place of Employment	Location Address (street, city, state, and ZIP)	Employment Setting (✓ one)
		☐ Public or non-profit agency ☐ Indigent or critical need populations within the state

PART IV - PERSONAL AND LICENSURE HISTORY

ALL OF THE FOLLOWING QUESTIONS MUST BE ANSWERED.
If you answer "YES" to ANY of the following questions, explain in full by addendum to the application. You must make a statement that includes, but is not limited to, the date(s), location(s), specific circumstances, practitioners and/or treatment involved, etc., pertaining to the "YES" answer. If you have been under treatment for a mental or physical illness or condition that affects your ability to practice dentistry/dental hygiene, you must request that each practitioner, hospital, and program involved in your treatment submit a full, detailed report of such to the board office. Any "YES" answer must be substantiated by either official documents sent directly to the board office from the respective state licensing board or official copies of court records. A "YES" answer is NOT an automatic cause for denial of licensure.

In addition to your submission of necessary documentation for any "YES" answer to these questions, your answers may result in your being referred to the Physicians Recovery Network (PRN) for evaluation. The PRN is a consultant to the State of Florida contracted to evaluate practitioners to ensure their ability to practice with reasonable skill and safety to the public. If you have any questions, the board staff may be able to assist you in determining whether the evaluation will be necessary in your case. Additionally, a personal appearance before the board may be requested in some cases, regardless of whether the PRN is involved.

NOTE: Obtaining or attempting to obtain a license by bribery, fraud, or knowing misrepresentation is a violation of the Dental Practice Act and may result in the denial of licensure, suspension or revocation of license, and/or other penalty under section 466.028, Florida Statutes, or Rule Chapter 64B5-13, F.A.C.

A. 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. If yes, please list date, jurisdiction (state and county), offense, disposition, and all other relevant information On reverse side or an attached sheet	YES NO
B. 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	YES NO

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offense(s) in another state or jurisdiction? (If you responded "no", skip to #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 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)?	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", do not answer 3a.)	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, do not answer 4a or 4b.)	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
6. If "yes" to any of the questions 1 through 5 above, on or before July 1, 2009, were you enrolled in an educational or training program in the profession in which you are seeking licensure that was recognized by this profession's licensing board or the Department of Health? (If "yes", please provide official documentation verifying your enrollment status.)	YES NO

7. Have you ever been denied the right to take a Dentistry or Dental Hygiene examination in any state?	YES NO
8. 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
9. Have you ever had a license revoked 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
10. 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
11. Is there currently pending against you in any jurisdiction a complaint against your professional conduct or competence as a Dentist or Dental Hygienist or other licensed professional? • If Questions 7-11 above are answered "YES", you must provide complete details as to state(s), license number(s), dates, and relevant circumstances on reverse side or on attached sheets.	YES NO

We are required to ask that you furnish the following information as part of your voluntary compliance with Section 2, Uniform Guidelines on Employee Selection Procedure (1978) 43 FR39298 (August 25, 1978). This information is gathered for statistical purposes only and does not in any way affect your candidacy for licensure.

Sex: ☐ F ☐ M **Are you a US Citizen?** ☐ Yes ☐ No **If no, give alien number**____________________________________

Ethnic Origin: ☐ Caucasian ☐ Black ☐ Hispanic ☐ Asian ☐ Native American ☐ Pacific Islander

Other________________________

PART V - APPLICANT RELEASE AND AFFIDAVIT

THE FOLLOWING STATEMENT MUST BE COMPLETED:

APPLICANT RELEASE AND AFFIDAVIT:

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I,____, state that I am the person referred to in the foregoing limited licensure application and supporting documentation, that said application and any supporting documentation are true and accurate, and that the attached photograph is a true likeness of myself.

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 limited licensure.

I hereby affirm that I have been licensed to practice the profession for which I now seek a limited license in a jurisdiction of the United States for at least 10 years. I affirm that I have retired from the practice of that profession and intend to practice only pursuant to the restrictions of the limited license. I understand that, once my limited license is granted, I may only practice in the employ of public agencies or institutions or nonprofit agencies or institutions which meet the requirements of s. 501(c)(3) of the Internal Revenue Code, and which provide professional liability coverage for my acts or omissions as the limited licensee. I also understand that, as a limited licensee, I may provide services only to the indigent or critical need populations within the state.

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 limited license to practice dentistry 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 signed____________________

SWORN AND SUBSCRIBED BEFORE ME THIS __________ day of ____________________________, __________.

In the County of____________________________________ State of ____

My commission expires on:____

(notary stamp or seal)

Notary signature:____

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FLORIDA DEPARTMENT OF HEALTH

CONFIDENTIAL AND EXEMPT FROM PUBLIC RECORDS DISCLOSURE

DEPARTMENT OF HEALTH

FLORIDA BOARD OF DENTISTRY

APPLICATION FOR DENTIST/DENTAL HYGIENIST LIMITED LICENSURE

This page is exempt from public records disclosure. The Department of Health is required and authorized to collect Social Security Numbers relating to applications for professional licensure pursuant to Title 42 USCA § 666 (a)(13). For all professions regulated under chapter 456, Florida Statutes, the collection of Social Security Numbers is required by section 456.013(1)(a), Florida Statutes.

Name: ____
Last First Middle

Social Security Number: ______________________________

PART VI - APPLICANT HISTORY - HEALTH

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.

Question	Answer
A. 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
B. 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
C. 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
D. 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
E. 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
F. 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

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LIMITED LICENSE FEE WAIVER FORM

TO BE COMPLETED BY EMPLOYER OR VOLUNTEER DENTIST/DENTAL HYGIENIST

Pursuant to Section 456.015, Florida Statutes and Rule 64B5-7.007, Florida Administrative Code, if a person applying for a limited license submits a notarized statement from the employing agency or institution stating that he/she will not receive monetary compensation for any services involving the practice of dentistry/dental hygiene, the licensure fees shall be waived.

AFFIDAVIT

I, ____, being first duly sworn, state that the following dentist/dental hygienist:

____

TYPE OR PRINT DENTIST/DENTAL HYGIENIST'S NAME

will NOT receive monetary compensation for any service involving the practice of dentistry/dental hygiene from:

Agency/Institution: ____

Address: ____

City/State/Zip: ____

Signed: ___________________________________

Name (type or print): _______________________________

Title: _________________________

STATE OF FLORIDA
COUNTY OF: ___________________________

The above person is personally known to me or has produced _______________ as identification.

SWORN AND SUBSCRIBED BEFORE ME
THIS ____________ DAY OF __________________, ____________
(month) (year)

(SEAL)

NOTARY PUBLIC: ______________________________________

MY COMMISSION EXPIRES: _____________________________

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