FLORIDA
DEPARTMENT OF HEALTH

BOARD OF DENTISTRY

HEALTH ACCESS DENTAL LICENSE 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

Definition from Chapter 466.003(14), F.S.

"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 s. 466.027, s. 466.028, 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.

REQUIREMENTS FOR HEALTH ACCESS DENTAL LICENSURE

- Has not been convicted of or pled nolo contendere to, regardless of adjudication, any felony or misdemeanor related to the practice of a health care profession;
- Submits proof of graduation from a dental school accredited by the Commission on Dental Accreditation of the American Dental Association or its successor agency;
- Submits documentation that she or he has completed, or will obtain prior to licensure, continuing education equivalent to this state's requirement for dentists licensed under s. 466.006, F.S., for the last full reporting biennium before applying for a health access dental license; (biennium begins March 1 of every even year, i.e. March 1, 2016 – February 28, 2018). See Rule 64B5-12.013, Florida Administrative Code, for continuing education requirements;
- Submits proof of her or his successful completion of parts I and II of the National Board of Dental Examiners Examination and a state or regional clinical dental licensing examination that the board has determined effectively measures the applicant's ability to practice safely;
- Currently holds a valid, active, dental license in good standing which has not been revoked, suspended, restricted, or otherwise disciplined from another of these United States, the District of Columbia, or a United States territory;
- Has never had a license revoked from another of these United States, the District of Columbia, or a United States territory;
- Has never failed the examination specified in s. 466.006, F.S., unless the applicant was reexamined pursuant to s. 466.006, F.S., and received a license to practice dentistry in this state;
- Has not been reported to the National Practitioner Data Bank, unless the applicant successfully appealed to have his or her name removed from the data bank;
- Submits proof that he or she has been engaged in the active, clinical practice of dentistry providing direct patient care for 5 years immediately preceding the date of application, or in instances when the applicant has graduated from an accredited dental school within the preceding 5 years, submits proof of continuous clinical practice providing direct patient care since graduation; and
- Has passed an examination covering the laws and rules of the practice of dentistry in this state as described in s. 466.006(4)(a), F.S.

Applicants are encouraged to thoroughly review s. 466.0067, F.S., before submitting the application.

LAWS AND RULES EXAMINATION REQUIREMENT

Applicants for health access dental licensure must successfully complete the Florida Laws and Rules examination with The Commission on Dental Competency Assessments (CDCA). Please visit www.cdcaexams.org to register.

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 the second year of the 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.

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.

Please make check or money order payable to the Department of Health and mail application and fee 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 under any circumstances.

CREDENTIALS

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

(2) **Final Official Transcript:** Dental transcripts sent to the Board of Dentistry by the registrar's office with appropriate stamps, seals, degree, and signatures are necessary. 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:** Applicants must contact the state board(s) in which a license has been held to request certification of licensure be sent to Florida. If the state has an online verification including disciplinary actions, the board office will accept the online verification.

(4) **Self-query of the National Practitioner's Data Bank:** Please view https://www.npdb.hrsa.gov/pract/howToGetStarted.jsp for information on obtaining a self- query and submit this with your application.

(5) **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.

(6) **Continuing Education**: Each applicant must submit documentation that she or he has completed, or will obtain prior to licensure, continuing education equivalent to this state's requirement for dentists licensed under s. 466.006, F.S., for the last full reporting biennium before applying for a health access dental license; (biennium begins March 1 of every even year, i.e. March 1, 2016 - February 28, 2018). See Rule 64B5-12.013, Florida Administrative Code, for continuing education requirements.

(7) **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 the name change document. All documentation must be official.

Please contact the Board office by telephone (850) 245-4474 or email info@floridasdentistry.gov if you have any questions.

Health Access Dental 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. 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 the following information as part of your voluntary compliance with Section 2, Uniform Guidelines on Employee Selection Procedure (1978) 43 FR 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

2. 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 Examination to the Florida Board of Dentistry. The contact information is: 211 East Chicago Avenue, Chicago, Illinois 60611, (800) 440-2811.

3. 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

4. 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.

5. 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

6. 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 sheets.

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

7. 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 _____

8. 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: #1, Applicant Profile Data.

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CONFIDENTIAL AND EXEMPT FROM PUBLIC RECORDS DISCLOSURE*

9. 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.

10. 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.