

The Commonwealth of Massachusetts
Division of Health Professions Licensure
Board of Registration in Dentistry
239 Causeway Street, 5th Floor, Suite 500
Boston, MA 02114
(617) 973-0971
www.mass.gov/dph/boards/dn

DENTAL LICENSURE BY CREDENTIALS

(See 234 CMR 4.04 Effective August 20, 2010)

Applicant Instructions

The Board may grant a license by credentials to a dentist currently licensed in another jurisdiction, provided the applicant has practiced a minimum of five (5) years, is of good moral character, has met all of the eligibility requirements, and has submitted the following information and documentation to the Board:

- An accurate, complete and signed application including CORI request form.
- Payment of a nonrefundable, nontransferable application fee.
- An original transcript with the college seal indicating the degree granted and the date of issue from a CODA-accredited dental, or a letter including the college's seal which is signed by the appropriate authority and attests to the applicant's degree and date of graduation
- A physician's statement that is the result of an examination, conducted within six months of the date of application, attesting to the health of the applicant and to any impairments which may affect the ability of the applicant to practice dentistry;
- Proof satisfactory to the Board of a minimum of five years of practice in dentistry or dental education immediately preceding the application for licensure by credentials.
- Proof satisfactory to the Board that the applicant is currently licensed and in good standing in another jurisdiction based on successful completion of an examination approved by the Board;
- Documentation of a passing score on each of the following exams:
 - (a) Parts I and II of the American Dental Association National Board Examination;
 - (b) The Northeast Regional Board (NERB) or other state or regional examination approved by the Board; and
 - (c) Massachusetts Dental Ethics and Jurisprudence Examination please email the Board at dentistry.admin@state.ma.us for a copy.
- Certified letters of standing from all jurisdictions in which the applicant has ever been issued a license to practice dentistry attesting to the standing of his/her license, including report of any past or pending disciplinary action, or any pending complaints against the applicant;
- Original report from the National Practitioner Data Bank (NPDB) Self-Query;
- Documentation demonstrating current certification in American Red Cross Cardiopulmonary Resuscitation/Automated External Defibrillation for the Professional Rescuer (CPR/AED) or ACLS/PALS.
- A statement disclosing any disciplinary action, civil and/or criminal action, or restriction of privileges taken against the applicant at any time prior to the date of application, with supporting documentation as may be required by the Board;
- Attach a passport-size photograph in color (2x2) to application where indicated. See http://travel.state.gov/passport/guide/composition/composition_874.html.

- Proof satisfactory to the Board of good moral character. Provide signatures on the application from two (2) licensed dentists (who do not need to be licensed in Massachusetts) familiar with the character and quality of the applicant. Immediate family members or close relatives do not qualify.
- Proof of 40 continuing education credits;
- An affidavit, signed under pains and penalties of perjury, and witnessed by a Notary Public.

Please Note:

- Incomplete applications will delay license processing.
- Please retain a copy of all application materials for your records.
- Confirmation of your license number will be available under "Online Services/Check a License" on our website www.mass.gov/dph/boards/dn as soon as the Board approves the license.

GENERAL INFORMATION

HOW TO OBTAIN PRESCRIPTION WRITING PRIVILEGES

A Massachusetts Controlled Substance Registration is required before a Federal (DEA) Controlled Substance Registration can be issued.

Massachusetts Department of Public Health

Division of Food and Drugs

Phone: (617) 983-6700

Fax: (617) 524-8062

Email: dep.dph@state.ma.us

State information and registration application forms may be obtained at :

www.mass.gov/dph/dep

U.S. Department of Justice

Drug Enforcement Agency

(617) 557-2100

1-800-882-9539

Federal information and registration application forms may be obtained at:

www.deadiversion.usdoj.gov

HOW TO REGISTER RADIATION EQUIPMENT

Massachusetts Department of Public Health

Radiation Control Program

Phone: (617) 242-3035

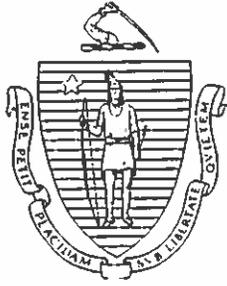
Fax: (617) 242-3457

State registration information and registration application forms are available at:

www.mass.gov/dph/rep

HOW TO FORM A CORPORATION OR APPLY FOR A CLINIC LICENSE

To form a corporation for a dental practice solely owned by dentists please contact the Secretary of State's office (617) 727-2828 to request form "Certificate by Regulatory Board." Submit a completed form (by mail or in person) and fee to our office for processing. A check or money order payable to the Commonwealth of Massachusetts for \$30 per dentist listed is required. If the practice is owned by non-dentists apply for a clinic license by contacting Division of Health Care Quality (617) 753-8000, www.mass.gov/dph/dheq



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BOARD USE ONLY

Receipt # _____

Fee : _____

Jurisprudence: Pass _____ Fail _____

APPLICATION --DENTAL LICENSURE BY CREDENTIALS

1. APPLICANT NAME: (Last) (First) (Middle)

2. MAIDEN NAME OTHER NAME:

3. ADDRESS OF RECORD: (No.) (Street) (Apt #)

(City) (State and or Country) (Zip Postal Code)
 Note: The address of record may be home or business and is public information

4. MOST RECENT PREVIOUS ADDRESS:

5. TELEPHONE NUMBER AND EMAIL ADDRESS: Day: Cell:

EMAIL ADDRESS:

6. Date of Birth (mm dd yyyy) Place of Birth (city state country) EYE COLOR:

HEIGHT: Feet Inches WEIGHT: lbs. MOTHER'S MAIDEN NAME:

7. SOCIAL SECURITY NUMBER (SSN) (disclosure is mandatory):
 Pursuant to M.G.L. c. 62C, s. 47A, the Division of Health Professions Licensure is required to obtain your SSN and forward it to the Massachusetts Department of Revenue. The Department of Revenue will use your SSN to ascertain whether or not you are in compliance with Massachusetts tax laws (M.G.L. c. 62C, s. 47A) and child support laws (M.G.L. c. 119A, s.16).

EDUCATION

8. GRADUATE OF:

Name ADA-Approved Dental School

City

State

Postal Code

Country

9. DATE D.D.S. OR D.M.D. CONFERRED BY AN ADA-APPROVED DENTAL SCHOOL: DATE

MM DD YYYY

DEGREE

AN OFFICIAL TRANSCRIPT OR ORIGINAL LETTER FROM THE DEAN'S OFFICE CONFIRMING THE ABOVE INFORMATION MUST BE ATTACHED.

10. NATIONAL BOARD CERTIFICATION PART I: DATE(S) COMPLETED

NATIONAL BOARD CERTIFICATION PART II: DATE(S) COMPLETED

11. REGIONAL OR STATE BOARD EXAMINATION (A COPY OF CERTIFICATE OR SCORES MUST BE ATTACHED TO THIS APPLICATION): PLEASE REFER TO THE BOARD'S WEBSITE WWW.MASS.GOV/DPH/BOARDS/DN FOR MORE INFORMATION.

CHECK HERE IF YOU HAVE TAKEN THE NERB

DATE OF EXAM

MM DD YYYY

OTHER EXAMINATION

DATE OF EXAM

MM DD YYYY

VERIFICATION OF OTHER LICENSES/BOARD REGISTRATIONS

12. LIST BELOW ALL PROFESSIONAL LICENSES OR REGISTRATIONS-- INCLUDING PROFESSIONS OTHER THAN DENTISTRY WHETHER OR NOT YOU HAVE PRACTICED UNDER THAT LICENSE OR REGISTRATION.

NOTE: Applicants must obtain official verification of each professional license or registration from each state or jurisdiction and submit it with this application.

I DO NOT CURRENTLY HOLD AND HAVE NEVER HELD A PROFESSIONAL LICENSE OR CERTIFICATION IN ANY STATE OR JURISDICTION

I CURRENTLY HOLD AND HAVE A PROFESSIONAL LICENSE OR REGISTRATION AS FOLLOWS:

Issuing Jurisdiction

Profession

License Certification Number

GOOD MORAL CHARACTER QUESTIONS

IF YOU ANSWER "YES" TO ANY OF THE FOLLOWING QUESTIONS PLEASE ATTACH A SEPARATE SHEET EXPLAINING THE CIRCUMSTANCES AND ALL RELEVANT DOCUMENTATION INCLUDING FINAL DISPOSITION.

13. Have you ever applied for and been denied a professional license in the United States or any country or foreign jurisdiction?

Yes No

14. Has any licensing or certification board, government authority, hospital or health care facility or professional medical association located in the United States or any country or foreign jurisdiction taken any disciplinary action against you?

Yes No

15. Are you the subject of pending disciplinary actions by any licensing or certification board, government authority, hospital or health care facility or professional medical association located in the United States or any country or foreign jurisdiction?

Yes No

16. Have you ever voluntarily surrendered any professional license or board certification in the United States or any country or foreign jurisdiction?

Yes No

17. Have you ever been arrested, charged, arraigned, indicted, prosecuted, convicted or been the subject of any criminal investigation or any court proceeding in relation to any criminal violation? Do not report minor violations for which a fine of \$100 or less was imposed.

Yes No

RECOMMENDATIONS OF GOOD MORAL CHARACTER

WE, THE UNDERSIGNED REGISTERED DENTISTS, ARE PERSONALLY ACQUAINTED WITH THE APPLICANT NAMED IN THE APPLICATION, AND RECOMMEND HIM HER AS A PERSON OF GOOD MORAL CHARACTER.

1. PRINTED NAME

STATE AND LICENSE NUMBER

ADDRESS

SIGNATURE

2. PRINTED NAME

STATE AND LICENSE NUMBER

ADDRESS

SIGNATURE

RELEASE

I hereby authorize all hospitals, institutions, credentialing agencies, organizations, personal physicians, employers (past and present), business and dental associates (past and present), and all government agencies and entities (local, state, federal, or foreign) to release to the Board of Registration in Dentistry any information, files or records requested by the Board in connection with the processing of my application. I further authorize the Board of Registration in Dentistry to release information contained in this application in association with its processing.

AFFIDAVIT OF APPLICANT

To the best of my knowledge and belief, I have filed all state tax returns and paid all state taxes required by state law and do not owe child support. I am aware of my professional obligations under M.G.L. c. 119 s. 51A, the reporting of suspected child abuse.

I understand that the Board is certified by the Massachusetts Criminal History Systems Board for access to Criminal Offender Record Information (CORI), including conviction and pending criminal case data. As an applicant for a license to practice as a dentist I understand that a CORI check may be conducted by the Board for conviction and pending criminal case information only and that the CORI results will not necessarily disqualify me.

I understand that I am responsible for reading and understanding the laws and regulations governing practice as a licensed dentist in Massachusetts and I hereby agree to comply with such laws and regulations.

I understand that this application for licensure as a dentist shall be deemed no longer valid if requirements for licensure as a dentist not met within one (1) year from the date of Board receipt. I also understand that fees are non-refundable and non-transferable.

I certify, under the pains and penalties of perjury, that the information I have provided pursuant to this application for licensure is truthful and accurate. I understand that any failure to provide truthful and accurate information in connection with this application for licensure may be grounds for the Board of Registration in Dentistry to deny issuance of a license; to suspend or revoke a license issued to me; and to deny renewal of a license issued to me, all in accordance with Massachusetts law.

To be completed, signed and witnessed by the applicant and Notary Public.

APPLICANT SIGNATURE: _____

DATE: _____

PRINT NAME: _____

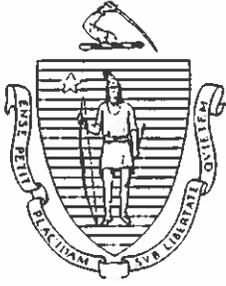
Attach a recent color
2x2 passport
photo

NOTARY NAME: _____

COMMISSION EXPIRES: _____

[Seal or Stamp]

INCLUDE A NON-REFUNDABLE, NON-TRANSFERABLE FEE FOR \$660 (CHECK OR MONEY ORDER) PAYABLE TO THE COMMONWEALTH OF MASSACHUSETTS



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CRIMINAL OFFENDER RECORD INFORMATION (CORI)
ACKNOWLEDGEMENT FORM

TO BE USED BY ORGANIZATIONS CONDUCTING CORI CHECKS FOR EMPLOYMENT, VOLUNTEER, SUBCONTRACTOR, LICENSING, AND HOUSING PURPOSES.

The Board of Registration in Dentistry is registered under the provisions of M.G.L. c. 6, § 172 to receive CORI for the purpose of screening current and otherwise qualified license applicants and current licensees.

As a prospective or current license applicant or current licensee, I understand that a CORI check will be submitted for my personal information to the Department of Criminal Justice Information Systems (DCJIS). I hereby acknowledge and provide permission to the Board of Registration in Dentistry to submit a CORI check for my information to the DCJIS. This authorization is valid for one year from the date of my signature. I may withdraw this authorization at any time by providing written notice of my intent to withdraw consent to a CORI check.

FOR EMPLOYMENT, VOLUNTEER, AND LICENSING PURPOSES ONLY:

The Board of Registration in Dentistry may conduct subsequent CORI checks within one year of the date this Form was signed by me provided, however, that Board of Registration in Dentistry must first provide me with written notice of this check.

By signing below, I provide my consent to a CORI check and acknowledge that the information provided on Page 2 of this Acknowledgement Form is true and accurate.

SIGNATURE

DATE

NOTE: The Board of Registration in Dentistry cannot accept this form unless it is either (1) signed in person at the Board's offices in the presence of a DIPL employee who has verified the applicant's identity through acceptable identification, or (2) signed in the presence of a notary public who has likewise verified identity and then mailed or hand-delivered to the Board's offices at the address set forth above.

CRIMINAL OFFENDER RECORD INFORMATION (CORI)
ACKNOWLEDGEMENT FORM

SUBJECT INFORMATION: (An asterisk (*) denotes a required field)

*Last Name *First Name Middle Name Suffix

Maiden Name (or other name(s) by which you have been known)

*Date of Birth Place of Birth

*Last Six Digits of Your Social Security Number: -

Sex: Height: ft. in. Eye Color: Race:

Driver's License or ID Number: State of Issue:

Mother's Full Name (Mother's Maiden Name)

Father's Full Name

Current and Former Addresses:

Street Number & Name City/Town State Zip

Street Number & Name City/Town State Zip

The above information was verified by reviewing the following form(s) of government-issued identification:

VERIFIED BY:

Name of Verifying DHPL Employee (Please Print)

ON

Date

Signature of Verifying DHPL Employee OR Notary Public

NOTARY NAME: _____

COMMISSION EXPIRES:

[Seal or stamp]

ATTACHMENT CHECKLIST

Your application cannot be processed without all of the following:

Attachment 1: Licensing Fee Personal or business check or money order must be made payable to the Commonwealth of Massachusetts in the amount of \$660. All fees are nonrefundable and nontransferable. Please do not staple to the application.

Attachment 2: Proof of Graduation - Original transcript from a DMD or DDS ADA-approved program with school seal indicating date and type of diploma issued **or** original signed letter from Dean's office indicating date of issuance of diploma must be included with application. Photocopy Not Accepted.

Attachment 3: National Board Certification Part I and II-Submit either a photocopy of certificate or original National Board Card issued by the ADA national board.

Attachment 4: Proof of Regional or State Clinical Examination - Proof of successful completion of regional or state clinical examinations must be attached to the application. NERB exam scores are sent to the Board monthly therefore a copy of NERB certificate is not necessary.

Attachment 5: Physician's Statement - Examination and signed statement on physician's stationery certifying that the candidate is fit to practice dentistry must have been completed within 6 months of application.

Attachment 6: Documentation of Current CPR/AED for the Professional Rescuer Certification or current ACLS/PALS certification

Attachment 7: Massachusetts Dental Ethics and Jurisprudence Exam-Answer sheet only.

Attachment 8: Proof of Continuing Education Credits - Copies certifying completion of 40 CEUs required for the 24 month prior to application must be attached to this application.

Attachment 9: Letters of Standing Verification of Professional Licensure from each state or jurisdiction in which you now hold or ever have held a license must be included in the application. The letter of verification of licensure must include the current status of the license, license number, the official seal of the jurisdiction's licensing Board and any disciplinary action taken. Photocopy of a license is not acceptable.

Attachment 10: Practice History - If you have ever practiced dentistry in another jurisdiction or state, please include an up- to-date resume or practice history, including employer's contact information and dates of employment.

Attachment 11: National Practitioner Data Bank Self-Query - (If you have ever held a professional healthcare license in the United States) To request a self-query please contact the Data Bank at 1-800-767-6732 or www.npdb-hipdb.hrsa.gov. The Data Bank will mail the report to you. Only an original report from NPDB will be accepted for this application.