

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

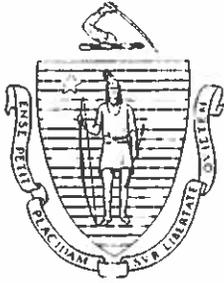
FULL-TIME FACULTY LICENSE RE-APPLICATION APPLICANT INSTRUCTIONS

(See 234 CMR 4.06 Effective August 20, 2010)

- A Full-Time Faculty License allows a full-time faculty member to perform all the duties of a dentist but only in a specifically named prison, hospital, school, or public clinic, under the supervision of a dentist licensed under M.G.L. c. 112 §45. **Private practice is not permitted. Faculty Limited Licenses may be re-applied for annually long as otherwise eligible.**
- A licensee who has been initially issued a limited full-time faculty license by the Board pursuant to M. G. L. c. 112, § 45A may apply to the Board annually to renew his/her limited license by submitting the applications, fees, documents and information required by the Board including the applicant's compliance with continuing education requirements at 234 CMR 8.02 (2).
- An individual who holds a license to practice dentistry pursuant to M. G. L. c. 112, §45A on or before August 20, 2010 shall be exempt from demonstrating proficiency in English (See 234 CMR 4.05 (7)).

PLEASE NOTE:

- Incomplete applications will delay license processing.
- Please retain a copy of all application materials for your records.
- Upon board approval, a certificate and a license number will be issued in your name and sent to your supervising dentist. 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.



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

BOARD USE ONLY

Receipt # _____

Fee : _____

Jurisprudence: Pass _____ Fail _____

FULL -TIME FACULTY LICENSURE RE-APPLICATION

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

2. MAIDEN NAME / OTHER NAME: _____

3. ADDRESS OF RECORD: _____
(No) (Street) (Apt /) (City or Town) (State or Country) (Zip Code)

Note: The address of record may be home or business and is, by law, 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. COMPLIANCE WITH 234 CMR 8.02(2) CONTINUING EDUCATION REQUIREMENTS

I certify that I have completed 20 hours of continuing education in the 12 months preceding this application.

Signature of Applicant

Print Name

Signature of Supervising Dentist

Print Name

VERIFICATION OF OTHER LICENSES/BOARD REGISTRATIONS

9. 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

PRACTICE LOCATION(S)

10. (A). NAME OF SPONSORING INSTITUTION CLINIC

ADDRESS

PHONE #

PRACTICE TO BEGIN:

MM DD.YYYY

SUPERVISING DENTIST NAME

MASSACHUSETTS DENTAL LICENSE #DN

I CERTIFY, UNDER PAINS AND PENALTIES OF PERJURY, THAT THE INFORMATION I HAVE PROVIDED PURSUANT TO THIS APPLICATION FOR LICENSURE IS TRUTHFUL AND ACCURATE.

SUPERVISING DENTIST SIGNATURE

10. (B). OTHER AFFILIATED PRACTICE LOCATION

ADDRESS

PHONE #

PRACTICE TO BEGIN:

MM DD.YYYY

SUPERVISING DENTIST NAME

MASSACHUSETTS DENTAL LICENSE #DN

I CERTIFY, UNDER PAINS AND PENALTIES OF PERJURY, THAT THE INFORMATION I HAVE PROVIDED PURSUANT TO THIS APPLICATION FOR LICENSURE IS TRUTHFUL AND ACCURATE.

SUPERVISING DENTIST SIGNATURE

10. (C). OTHER AFFILIATED PRACTICE LOCATION

ADDRESS

PHONE #

PRACTICE TO BEGIN:

MM DD.YYYY

SUPERVISING DENTIST NAME

MASSACHUSETTS DENTAL LICENSE #DN

I CERTIFY, UNDER PAINS AND PENALTIES OF PERJURY, THAT THE INFORMATION I HAVE PROVIDED PURSUANT TO THIS APPLICATION FOR LICENSURE IS TRUTHFUL AND ACCURATE.

SUPERVISING DENTIST SIGNATURE

GOOD MORAL CHARACTER QUESTIONS

IF YOU ANSWER "YES" TO ANY OF THE FOLLOWING QUESTIONS PLEASE ATTACH A SEPARATE SHEET EXPLAINING THE CIRCUMSTANCES. ALSO PROVIDE ALL RELEVANT CERTIFIED DOCUMENTATION (POLICE REPORTS, COURT RECORDS, DISCIPLINARY ACTION REPORTS, ETC.) INCLUDING FINAL DISPOSITION OF THE MATTER.

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

Yes No

12. 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

13. 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

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

Yes No

15. 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

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 full-time faculty limited licensed 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 full-time faculty limited licensed dentist in Massachusetts and I hereby agree to comply with such laws and regulations.

I understand that this application for licensure shall be deemed no longer valid if requirements for licensure as a full-time faculty limited licensed dentist are 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 a Notary Public.

APPLICANT SIGNATURE

DATE

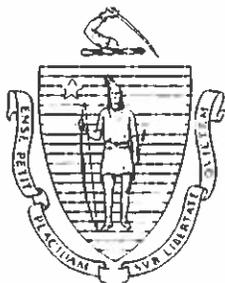
PRINT NAME

NOTARY PUBLIC NAME:

NOTARY PUBLIC COMMISSION EXPIRES:

[Seal or Stamp]

**SUBMIT A NON-REFUNDABLE AND NON-TRANSFERABLE FEE FOR \$90 (CHECK OR MONEY ORDER)
PAYABLE TO THE COMMONWEALTH OF MASSACHUSETTS**



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

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

VERIFIED BY: _____
Name of Verifying DIHPL Employee (Please Print)

ON _____
Date

Signature of Verifying DIHPL Employee OR Notary Public

NOTARY NAME :

COMMISSION EXPIRES :

[Seal or stamp]

ATTACHMENT CHECKLIST

Your application cannot be processed without all of the following, as applicable:

Attachment 1: Licensing Fee - Personal or business check or money order made payable to the Commonwealth of Massachusetts for \$90.00. Cash is not accepted. All fees are non-refundable and non-transferable. Please do not staple check or money order to the application.

Attachment 2: Documentation of Current CPR/AED for the Professional Rescuer or Current BLS Certification

Attachment 3: Confirmation of Full-Time Faculty Appointment - An original letter signed by a school official on institutional stationery, to include dates of faculty appointment.

Attachment 4: Letters of Standing - Verification of Professional Licensure from each state or jurisdiction in which you hold or have ever 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 actions taken. A photocopy of a license is not acceptable.

Attachment 5 : National Practitioner Data Bank Self-Query Report (If you have ever held a professional healthcare license in the United States) To request a self-query report, 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.