*The he Commonwealth of Massachusetts Executive Office of Health and Human Services Department of Public Health Bureau of Health Professions Licensure*

*Board of Registration in* [*Dentistry*](https://www.mass.gov/orgs/board-of-registration-in-dentistry)

**TEMPORARY Licensure by Reciprocity Application**

**Please note TEMPORARY licensure is no longer valid when the Public Health Emergency is NO longer in effect**

**Select Application Type:** Dentist:  Dental Hygienist:  Dental Assistant:

To complete this application you must answer all questions. Please read each question carefully and provide accurate information.

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

**Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Maiden/Other Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Social Security Number: \_\_\_\_\_-\_\_\_\_\_\_-\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Mailing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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Please list below your initial license information for the temporary license type you are applying for in Massachusetts and license information for the state you are currently practicing.

|  |  |  |  |
| --- | --- | --- | --- |
|  | **State** | **License Number** | **Year Issued** |
| **Initial State of Licensure** |  |  |  |
| **List all states of Licensure**  **(add additional pages if necessary)** |  |  |  |
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| **Attestation:** Under the penalties of perjury, I declare that to the best of my knowledge and belief, the information contained herein is true, correct and complete. I understand that any falsification or misrepresentation of any item on this application may be a sufficient basis for denying or revoking a license. I also declare I will cease to practice in the Commonwealth of Massachusetts when the Emergency order is no longer in effect.  **SIGNATURE: DATE: \_ \_** |

# To submit this form fax securely to: (617) 973-0980, or mail to 239 Causeway St., Suite 500, 5th Floor, Boston, MA 02114, at the ATTN of the Board of Registration in Dentistry. Please do not email this form, as it contains confidential, personal information.

*Page 1 of 1 Revised 4.3.2020*