*The 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)

**Emergency Reactivation Application**

Please note this reactivation application is applicable only to: “Individuals who have within the last ten years, held a license to practice as a health care provider that was issued by a Massachusetts licensing authority, including but not limited to a state agency, a board of registration or division with licensing authority within a state agency, and whose license, registration, certification or authorization has expired, lapsed or been retired but is not revoked, suspended, surrendered or subject to any non-disciplinary restriction shall have their licenses immediately renewed or reactivated upon request, notwithstanding the applicant’s completion of continuing education, or reactivation requirements, and shall remain valid until 90 days following the termination of the state of emergency. Any applicable renewal fee set pursuant to section 3B of chapter 7, or late renewal fee shall be waived.”

**Select Application Type:**

Dentist: [ ]  Dental Hygienist: [ ]  Dental Assistant: [ ]  **License Number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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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Has any licensing or certification board, government authority, hospital or health care facility or professional

association located in the United States or any country or foreign jurisdiction taken any disciplinary action against

you?

Yes[ ]  (if yes, submit an attached sheet with a description) No [ ]

|  |
| --- |
| **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. **SIGNATURE: DATE: \_ \_** |

# To submit this form fax securely to: (617) 973-0983, 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.

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