

Application for Dental Licensure

Enclosed is the application for Georgia dental licensure. **Please read all supporting documents below before completing the attached application. NOTE: The fees are non-refundable.** The licensure process could take up to a minimum of **30 days** after submission of a completed application. Plan your application time accordingly.

All questions on the application must be answered.

ATTENTION: ALL SUPPORTING DOCUMENTS MUST BE MAILED WITH COMPLETED APPLICATION IN ONE PACKAGE TO THE BOARD OFFICE.

In order to verify your compliance with licensure requirements submit:

1. **Completed application form** accompanied by a fee of \$100.00 (subject to change). Your application will not be processed unless the fee and all supporting documents are received. This is only an application fee. If licensure is granted, the license will be required to be renewed by the last day of December in ODD numbered years, regardless of when you were originally licensed. Personal checks or money orders are acceptable, payable to the order of **Georgia Board of Dentistry. FEES ARE NON-REFUNDABLE.** **Checks returned for insufficient funds will be assessed a \$30 service charge pursuant to O.C.G.A. § 16-9-20.**
2. **Incomplete applications** are maintained in the Board office for a period of one (1) Year. After such time the application is rendered **void** and the applicant **must** re-apply and pay all required fees.
3. **Official letter(s) of licensure verification** for **every** dental license **ever** held. Each letter must indicate the date of licensure, the licensure status (active, inactive, expired, revoked, etc.) standing of license, any disciplinary charges made against you by the licensing board or by any other state agency, and the result of these actions. The applicant must provide a copy of the formal complaint/pleading, outcomes, and a personal written explanation for each instance of discipline. You should call each state board about fees for these services. **The letter(s) must be submitted with your application IN THE ORIGINAL SEALED ENVELOPE FROM THE BOARD OF EACH LICENSING STATE,** and must be dated within four months of Board receipt of your complete application packet.
4. **An Official Transcript** which documents graduation with a D.D.S. or D.M.D. degree from a dental school which is accredited by the American Dental Association Commission on Dental Education. **The transcript must be IN THE ORIGINAL SEALED ENVELOPE FROM THE COLLEGE.** Graduates from a non-accredited school please see Rule 150-3-.04 and O.C.G.A. § 43-11-40(a)(1)(A) and (B).
5. **National Board Scores** from the ADA Joint Commission on National Dental examinations. The ADA (1-800-621-8099) will send a copy of National Board scores to state licensure boards only. If you ask the ADA to send our board a copy of your

National Board scores, so indicate in your application packet. **DO NOT SUBMIT THE NATIONAL BOARD CERTIFICATE. YOUR NATIONAL BOARD SCORE MUST COME DIRECTLY FROM THE ADA TO BOARD OFFICE.**

6. **Proof of having successfully passed the Southern Regional Testing Agency (SRTA) examination**, if you took SRTA after February 1993. You must submit a notarized photocopy of your SRTA score card. SRTA may be contacted through their website at www.srta.org or by telephone (757) 318-9082.
7. **Jurisprudence Examination** The examination must be downloaded from our website (see-applications and other forms) The study materials are also on our website. (www.sos.state.ga.us/plb/dentistry) The fee for this examination is \$25.00, payable to the order of **Georgia Board of Dentistry**. **FEES ARE NON REFUNDABLE.**
A score of 75 or higher is considered a passing score.
8. **A National Practitioner Data Bank(NPDB)** certified report of any pending or final disciplinary actions or malpractice actions against any license ever held by the applicant in any state. **All applicants must submit a NPDB report along with a completed application.** (NPDB must dated within four months). The **ONLY** applicants exempted from the requirement of NPDB report submission are those applicants within 6 months of dental school graduation who have never been issued a dental license in any state or U.S. territory. The NPDB report **must** be received in the **ORIGINAL SEALED ENVELOPE FROM NPDB.** Those applications which have any disciplinary or malpractice case(s) (open & closed) will be considered for licensure on a case by case basis, after receipt of all required application materials. For each case, the applicant must submit: 1) a copy of the formal complaint pleadings filed by the plaintiff/complainant or State Regulatory Agency, 2) a copy of the final action, disposition, or settlement, 3) a personal explanation of the disciplinary action or the malpractice claim, and 4) any further information requested by the Board in separate communications. To obtain information (self-query) from the NPDB-HIPDB, please visit www.npdb-hipdb.com, scroll to the right side of the home page, and click **Perform a Self-Query**. The self-query is \$20.00, payable by credit card (VISA, MasterCard, Discover, or American Express). If you do not have Internet access, contact the Customer Service Center at 1-800-767-6732 from 8:30 a.m. to 6:00 p.m. Eastern Time (8:30 a.m. to 5:30 p.m. Fridays).
9. **Copy of Court Document or Affidavit** explaining any discrepancies of the applicant's name if documents submitted bear different name(s).[i.e. marriage certificate, divorce decree, legal name change]
10. **Current CPR certification** (photocopy)

Relocation: If you relocate during the time that your application is being processed, you **must** notify the Board of your new address in writing by fax (478) 207-1699 or mail. This will enable you to receive Board correspondence.

SUBMIT YOUR COMPLETED APPLICATION PACKET TO

**Georgia Board of Dentistry
237 Coliseum Drive
Macon, Georgia 31217**



Do Not Write In This Section:

Receipt#: _____

Amount: _____

Applicant #: _____

Initials/Date: _____

Board Name: Georgia Board of Dentistry
Address: 237 Coliseum Drive
Address: Macon, GA 31217-3858
Telephone #: (478) 207-2445
Fax #: (478) 207-1699
Website: www.sos.state.ga.us/plb/dentistry

Application For: Dental License

Obtained By Method: Application \$125 Non-Refundable Fee (\$100 Application Fee \$25 Exam)

Checks returned for insufficient funds will be assessed a \$30 service charge pursuant to O.C.G.A. § 16-9-20

DISABILITY- If you have a disability and may require an accommodation, you must contact the Board to obtain the REQUEST FOR DISABILITY ACCOMMODATIONS GUIDELINES.

VETERANS PREFERENCE POINTS- Veterans may be eligible for special benefits in testing. For more information, contact the Board office. **Submit copy of DD-214 with your application.**

Part I: Personal Information

1. Name: _____
Last First Middle Maiden

2. Mailing Address: _____
(Street) (Apt. #) (City/State/Zip Code)

3. **If your mailing address is a P.O. Box, you must provide a physical address:**

(Street) (Apt. #) (City/State/Zip Code)

If you are granted a license, your name, mailing address and license number are public information.

4. E-Mail Address: _____

5. Telephone #: Home: () _____ Work () _____ Other () _____

6. Date of Birth: _____ 7. Gender: ___M ___F

8. Race: _____ 9. Ethnicity: ___(Hispanic or Latino) ___(Not Hispanic or Latino)

10. Social Security Number*: _____ - _____ - _____

11. Military Service: _____ Dates of Service: _____
Honorable/Dishonorable Discharge: _____

*This information is authorized to be obtained and disclosed to state and federal agencies pursuant to O.C.G.A. §19-11-1 and O.C.G.A. §20-3-295, 42 U.S.C.A. §551 and 20 U.S.C.A. §1001. It may also be disclosed to the National Practitioner's Databank (NPDB) and the Healthcare Integrity and Protection Data Bank (HIPDB) or other licensing boards, or other regulatory agencies for license tracking purposes.

Part II: Professional Education

12. Highest Degree Earned: ___Doctorate ___Master ___Bachelor ___Associate
____Diploma/Certificate

13. Name/Address of Entry Level Professional Institution (e.g. technical school, undergraduate college/university): _____

- a. Dates Attended: _____ c. Graduation Date: _____
b. Major: _____ d. Degree(s) Earned: _____

14. Name/Address of Graduate School/University: _____

- a. Dates Attended: _____ c. Graduation Date: _____
b. Major: _____ d. Degree(s) Earned: _____

15. Name/Address of Post-Graduate School/Hospital (if applicable): _____

- a. Type of Training: _____ b. Dates Attended: _____

16. National Board Information:

I understand that it is my responsibility to see that a copy of my scores be mailed from the Joint Commission on National Dental Examinations directly to the Board. For your convenience, the number is: 1-800-621-8099.

Signature of Applicant

17. Southern Regional Testing Agency Information:

I understand the Georgia Board of Dentistry accepts the results from the Southern Regional Testing Agency, but it is my responsibility to send a notarized copy of those results to the Georgia Board of Dentistry. For your convenience, the number is: 757-318-9082.

Signature of Applicant

18. National Practitioners Data Bank/Healthcare Integrity and Protection Data Bank

The Georgia Board of Dentistry requires all candidates for licensure to query the **NPDB/HIPDB** before licensure will be granted: You may contact the NPDB/HIPDB by calling: 1-800-767-6732 or by submitting your query online at: www.NPDB.com. (When you receive the **RESPONSE** from the NPDB/HIPDB please forward the information to the Board office along with your completed application). **If you are a recent graduate (within the past six months) and not licensed in any other state, you are exempt from this requirement.**

19. Did you require special accommodations for the examination administered by the Southern Regional Testing Agency as outlined in the Americans with Disabilities Act? Yes No **If yes, what accommodations were made?**

20. Have you ever failed a portion of the Southern Regional Testing Agency Examination or any other regional or state clinical examination?
 Yes No **If yes, give dates (list regional or state if applicable).**

If you've failed this exam three (3) or more times please request an exam history from SRTA or any other regional or state board.

Part III:

If yes to any of the following questions you must attach a full written explanation pertaining to that particular question.

21. Was your pre-dental education or dental education interrupted, other than the usual vacation periods?
 Yes No

22. Do you presently have any contagious or infectious disease? Yes No

23. Have you ever been charged with driving under the influence of alcohol or drugs? Yes No
24. Have you ever had a formal complaint filed against you with any dental society, association, hospital, or dental board? Yes No
25. Has any state licensing board revoked or suspended your certificate/license, or taken other disciplinary action? Yes No
26. Have you ever been denied a DEA registration number or been issued a restricted DEA registration? Yes No
27. Have you ever voluntarily surrendered a dental license, a controlled substances registration, or DEA registration? Yes No
28. Have you ever had any malpractice suits filed against you? Yes No
29. Have you ever been denied participation in, or suspended from the Medicaid or Medicare benefit program? Yes No
30. Have you ever been denied issuance of or, pursuant to disciplinary proceedings, refused renewal of a license by any board or agency in Georgia or any other state? Yes No
31. Have you ever been denied the privilege of taking an examination before any Dental Board or licensing authority? Yes No
32. Have you ever failed an examination required of any Dental Board or other licensing authority? Yes No
33. Have you ever been refused any privilege of prescribing controlled substances, or had any prescribing privileges of controlled suspended or revoked? Yes No
34. Have you ever been refused, or suspended from membership in a dental society, or association, or hospital staff? Yes No
35. Have you ever personally used narcotics or alcohol excessively or have you ever undergone treatment for addiction to alcohol or other controlled substances or habit forming substances? Yes No
36. Have you ever been summoned, arrested, taken into custody, indicted, convicted or tried for, or charged with, or pled guilty to, or pled, nolo contendere to, a violation of any law or ordinance or the commission of any felony or misdemeanor (excluding minor traffic violations), (DWI & DUI are **not** minor traffic violations), or have you been requested to appear before a prosecuting attorney or investigative agency in any matter? Yes No

(Although a conviction may have been expunged from the records by order of court, it nevertheless must be disclosed in your answer to this question). If yes, for **each** occurrence furnish a written statement giving the complete facts in your own words, including in such statement the date, name and nature of the offense, the name and locality of the court, and the disposition of each such matter. **You must attach the court disposition.**

37. Are there any other facts not disclosed by your answers which may have a bearing on your fitness or eligibility to practice dentistry in Georgia and which should be placed at the disposal or brought to the attention of the State Board of Dentistry? Yes No

38. Out of State Licensure Certification(s):

List all states which you have been issued a license to practice dentistry: (active, inactive, revoked, suspended, expired, lapsed etc.) You should have each state listed send an official letter of licensure verification/certification. See instruction sheet for details. **If not applicable check here:** () n/a and initial

<u>STATE</u>	<u>DATE OF LICENSURE</u>	<u>LICENSE STATUS</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

39. References: Listed below are two references whom I have supplied with the proper form that was included in my application packet.

I understand that it is my responsibility to see that these forms are returned. I certify these references are not related to me, nor are they connected with any dental college I attended.

Name_____

Name_____

Address_____

Address_____

City, State, Zip_____

City, State, Zip_____

Occupation_____

Occupation_____

Part IV:

40. AFFIDAVIT OF APPLICATION

I acknowledge and state that I have read the Application and Instructions that accompanied this application and I have answered all questions in compliance with these instructions. I acknowledge that it is my responsibility to read and become familiar with the Dental Practice Act and the Board Rules.

I further state that by submitting this application for a license to practice dentistry/dental hygiene in the State of Georgia, I hereby authorize and consent to have an investigation made as to the moral character, professional reputation and fitness for the practice of dentistry/ dental hygiene. I agree to give any further information in which may be required in reference to my past record. I understand that I will not receive a copy of the report or know its contents and I further understand that the contents of the investigative report will be privileged unless determined otherwise by the Board of Court Order.

I authorize and request every person, hospital, clinic, community, governmental agency (local, state, federal or foreign), court, association, institution, or other organization having control of any documents, records and other information pertaining to me, to furnish to the Georgia Board of Dentistry any information, including documents, records, regarding charges or complaints filed against me, formal or informal, pending or closed, or any other pertinent data and to permit the Georgia Board of Dentistry or any of its agents or representatives to inspect and make copies of such documents, records and other information, in connection with this application, subsequent licensure or practice thereunder.

I hereby release, discharge and exonerate the Georgia Board of Dentistry, it's agents or representatives, and any person so furnishing information, from any and all liability of every nature and kind arising out of the furnishing or inspection of such documents, records or other information or the investigation made by the Georgia Board of Dentistry. I authorize the Georgia Board of Dentistry to release information, material, documents, orders or the like relating to me or to this application to any other State or Territory of the United States or Province of Canada, a law enforcement agency, a hospital or other appropriate agencies as determined by the Board.

This is to certify that the foregoing information is true and correct to the best of my knowledge.

Signature of Applicant

Date _____

(Print Name Above)

County _____ State _____

being duly sworn, says that he/she is the person who executed the above application for license to practice dentistry/dental hygiene in the State of Georgia; and that all the statements herein contained are true in every respect and that the attached photo is a true photo of the applicant.

(PHOTOGRAPH)
Please attach recent photograph

Notary Public

Sworn to and subscribed before me this _____ day of _____, _____.

(SEAL) My Commission Expires _____

Notary: Do not notarize this section unless photograph is attached.

Part V: STATE LICENSURE CERTIFICATION

TO THE APPLICANT: *Please complete the top section of this form and mail to each state in which you are now or have been licensed to practice dentistry. This form may be reproduced as necessary.*

TO: _____ **Board of Dentistry**

I am applying for licensure and the Georgia Board requires that your Board complete this form in order that my application for licensure may be considered. By signing this form, I am giving my consent to the release of any information, favorable or otherwise, for its review in considering me for licensure.

My license Number _____ was issued by your Board on _____ on the basis of () State Board Exam, () Reciprocity/Endorsement, () National Board, () Credentials, () other _____.

Applicant's Full Name (print or type)	Address		
Signature	City	State	ZIP

This section to be completed by an official of the above referenced licensing board. Please return this form directly to the applicant in a sealed envelope.

Dental License Number _____ to practice dentistry in the State of _____ was issued on _____ to _____.

Licensee

Is license current and in good standing? ___ Yes ___ No*

Has any disciplinary action ever been taken against this license?

___ Yes* ___ NO *If yes, please attach disciplinary documents.

* Please provide complete details, including copies of any documents.

Signature	Date
Title	(BOARD SEAL)

Licensing Board

GEORGIA BOARD OF DENTISTRY

237 Coliseum Drive
Macon, Georgia 31217-3858
(478) 207-2445

(You may duplicate this form)

TO THE REFERENCE: The person listed below is applying for licensure as a dentist in the State of Georgia. The applicant is required to furnish satisfactory evidence that he/she is qualified to practice professional dentistry. You have been given this form as one who knows the applicant well and can attest to his/her character, ability, reputation, and professional attainments.

The statements you provide must be from personal knowledge only, and should be made with full realization of the responsibility toward the public involved. You should answer fully, carefully, and with the utmost frankness.

Be assured that the information you furnish will be treated as **strictly confidential**. Please return your recommendation directly to the applicant. **RETURN TO APPLICANT IN A SEALED ENVELOPE.**

NAME OF APPLICANT _____

FROM _____
Reference Full Name (Daytime telephone # including area code)

_____ Address

_____ City Zip Code

1. Are you a licensed dentist? ___ Yes ___ No If yes, what state(s)? _____

If no, what is your present profession? _____

2. How long have you known the applicant? ___ Years. Are you related? _____

3. In what capacity have you known him/her _____

4. Do you know anything reflecting adversely on the applicant's integrity or general good character?
_____ Yes _____ No **If yes, give details on a separate page.**

5. Do you feel that this applicant is qualified to have responsibility of a dental office? _____ Yes
_____ No **If no, give details on a separate page.**

6. Would you feel comfortable going to this person for your dental needs? _____ Yes _____ No
If no, give details on a separate page.

7. What is the applicant's character, reputation, and standing in the community?

page 2 Reference Form continued

NAME OF APPLICANT _____

FROM _____

Additional Comments _____

The undersigned certifies that the above statements, to the best of his/her knowledge and belief, are correct.

Signature

Title

Date