

North Dakota State Board of Dental Examiners

PO Box 7246, Bismarck, ND 58502 • Phone 701-258-8600 • Fax 701-224-9824
Web www.nddentalboard.org • Email ndsbd@aptnd.com

Medical Evaluation of License Applicant

Dear Doctor,

The North Dakota State Board of Dental Examiners is conducting a review of the professional credentials of an applicant for a license to practice dentistry or dental hygiene in the State of North Dakota. One of the requirements for licensure is a statement by a licensed physician that the applicant has been examined and found physically and mentally acceptable to engage safely in the practice of dentistry or dental hygiene.

Please examine the applicant, at his or her own expense, and provide the North Dakota State Board of Dental Examiners with your professional assessment of the applicant's fitness to engage in the practice of dentistry or dental hygiene. Please send the report directly to the administrative secretary at your earliest convenience. The applicant's authorization for you to provide this information directly to the North Dakota State Board of Dental Examiners is provided below.

Sincerely,
NDSBDE

AUTHORIZATION TO CONDUCT BACKGROUND INVESTIGATION AND MEDICAL EVALUATION

I, _____, authorize the North Dakota State Board of Dental Examiners to review my medical, personal, and professional background so that my suitability to practice dentistry in the State of North Dakota can be evaluated. I hereby give my permission to the North Dakota State Board of Dental Examiners to evaluate my clinical competence and suitability to practice by reviewing any aspect of my personal history, medical history, or any aspect of my history of professional practice which could in any way reflect on my suitability to practice dentistry or dental hygiene. I authorize any person or organization to provide any information to the North Dakota State Board of Dental Examiners which bears on my suitability to practice dentistry or dental hygiene. Further, I agree to hold harmless any person or organization providing such information to the North Dakota State Board of Dental Examiners. I understand and acknowledge that full disclosure of all material facts is required for the proper evaluation of my credentials. I understand that withholding significant information or facts constitutes grounds for not issuing a license or later revocation of any license which may have been issued based on incomplete, misleading, or false information.

Signature _____ Address _____ Date _____

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Confidential Professional Reference and Medical Evaluation

From:

Reference Applicant: _____

- I have examined the above named applicant and find no medical or mental condition, which precludes the safe practice of dentistry or dental hygiene. My examination reveals that the examinee is not chemically dependent, nor do I find that the examinee has any physical or mental disabilities.
- I have examined the above named applicant and find the following conditions, which may have an impact on this person's ability to safely render health care to patients as a dentist or dental hygienist:

1.

2.

Physician Name (Print)

Signature of Physician

Date

Address

(_____)_____
Office Phone Number

City, State, Postal Code

The applicant's visual acuity is sufficient to permit the safe practice of dentistry or dental hygiene.

Optometrist Name (Print)

Signature of Optometrist

Date

Address

(_____)_____
Office Phone Number

City, State, Postal Code