North Dakota Board of Dental Examiners

PO Box 7246, Bismarck, ND 58507-7246 • Phone 701-258-8600 • Fax 701-224-9824
Web www.nddentalboard.org • Email info@nddentalboard.org

APPLICATION FOR DENTAL LICENSE BY EXAMINATION

NON-REFUNDABLE APPLICATION FEE $440

REQUIREMENTS FOR LICENSURE

☐ **COMPLETED AND NOTORIZED APPLICATION** - **All license applications must be received in the Board office 30 days prior to the next Board meeting** (See NDCC § 43-28-11). However, transcripts, references, test scores, verifications and other documents may still be received by the Board after the 30-day deadline. To receive notice that your application has been delivered to the board, it is suggested that the application be mailed by "Certified Mail-Return Receipt Requested" or with "Delivery Confirmation". Attach and sign photo taken within 6 months to the application (no staples please).

If you answered YES to questions pertaining to charges, crimes etc; the Board will require copy of evaluation and recommendations for treatment if any were issued; a copy of the criminal charges, reported offense and dates, police report and judgment and disposition of criminal complaint; disposition of the offense, final disposition, any orders or any actions pending. Please send your information directly to the Board as soon as you can. If you answered YES to a question regarding "ever being named as a defendant or respondent in any malpractice proceedings" please send a copy of your resolution documentation such as a default judgment, summary judgment, voluntary dismissal, involuntary dismissal, or settlement.

☐ **LICENSE FEE – LICENSE FEES ARE NONREFUNDABLE -** If the fee is not submitted with the application the application will be returned. The Board will not return other items sent by the applicant such as references, or transcripts. If an applicant fails to complete all of the requirements for licensure within 6 months from the postmarked date the application and fee are no longer valid [See Section 20-02-01-03.3]. Please read laws and rules regarding licensure application carefully. License fees are nonrefundable.

☐ **SPOUSE OF A MEMBER OF THE ARMED FORCES OF THE UNTIED STATES OR A RESERVE COMPONENT OF THE ARMED FORCES OF THE UNITED STATES IN ACCORDANCE WITH MILITARY ORDERS OR STATIONED IN THIS STATE BEFORE A TEMPORARY ASSIGNMENT TO DUTIES OUTSIDE THIS STATE –** Upon request, the Board may issue a provisional license or temporary permit not to exceed two years and remains valid while the military spouse is making progress toward satisfying the unmet licensure requirements. The applicant must demonstrate competency by standards as issued by the Board which must include demonstrating experience in the profession at least two of the four years preceding the date of application. Pursuant to NDCC 43-51-11.1 the Board may require an applicant to submit to a statewide and national criminal history record check. A military spouse issued a temporary permit or provisional license has the same rights and duties as a licensee issued a license under the traditional licensure method.

☐ **CRIMINAL BACKGROUND CHECK** – Applicants are required to submit fingerprints and undergo a criminal background check. The appropriate forms will be sent to you upon receipt of your application and application fee. Return the fingerprint forms which may be completed by local law enforcement or fingerprinting service center which may take digital prints. Submit both fingerprint cards to the NDSBDE with your check or money order payable to the ND Attorney General. The process may take up to ten business days. Results shall be received by the board prior to the issuance of a license to practice. Check with local law enforcement for scheduling. **FINGERPRINTS WILL BE USED TO CHECK THE CRIMINAL HISTORY RECORDS OF THE FBI. THE BOARD PROVIDES THE APPLICANT THE OPPORTUNITY TO COMPLETE, OR CHALLENGE THE ACCURACY OF, THE INFORMATION CONTAINED IN THE FBI IDENTIFCATION RECORD. APPLICANTS ARE ADVISED THAT PROCEDURES FOR OBTAINING A CHANGE, CORRECTION, OR UPDATEING OF AN FBI IDENTIFICATION RECORD ARE SET FORTH IN TITLE 28, C.F.R., § 16.34. GRANTING OF LICENSURE SHALL NOT BE BASED ON INFORMATION IN THE RECORD UNTIL THE APPLICANT HAS BEEN AFFORDED A REASONABLE TIME TO CORRECT OR COMPLETE THE RECORD, OR HAS DECLINED TO DO SO.**

☐ **DIPLOMA** – submit an 8" x 11" copy.

☐ **OFFICIAL TRANSCRIPT** –A **FINAL** transcript must be sent to the Board office directly by the school and must show the date of graduation, the degree or certification earned, and have the seal of the school. It is the applicant's responsibility to arrange to have the transcript mailed directly to the Board office from the school. (Copies, transcripts that are not in English, student transcripts or incomplete transcripts are not acceptable.)

☐ **NATIONAL BOARD RESULTS** - Provide a notarized copy of successful National Board results taken within five years of application. Contact the Joint Commission on National Dental Examinations, 211 E. Chicago Avenue, Ste 600, Chicago, Illinois 60611-2637, telephone (800) 232-1694, or website: **www.ada.org/1635.aspx**, to request that an OFFICIAL REPORT of your National Board or Canadian National Examining Board scores be sent directly to the Board office. Dental applicants may also send an e-mail to nbexams@ada.org. Copies that are not sent directly from the JCNDE must be notarized.

☐ **CLINICAL EXAM RESULT** - Provide evidence of successful completion of a Board approved clinical examination taken within five (5) years of application given by a regional testing service. The Board accepts all regional clinical exams however the Canadian OSCE exam is not accepted in lieu of the clinical board requirement. Required components must include a **patient-based** periodontal component, a patient based restorative component, an endodontic component, administered by one or more of the following; CRDTS, CITA, NERB, WREB, or SRTA. Copies must be notarized. BE ADVISED, PENDING AMENDMENTS TO THE NORTH DAKOTA ADMINISTRATIVE CODE, REVISED COMPONENTS FOR THE CLINICAL COMPETENCY EXAM SHALL REQUIRE A PATIENT-BASED POSTERIOR COMPOSITE OR AMALGAM RESTORATION, A PATIENT BASED PERIODONTAL COMPONENT, AN ENDODONTIC COMPONENT, AND A FIXED PROSTHETIC COMPONENT. UPDATES WILL BE POSTED TO THE BOARD'S WEBSITE OR YOU MAY CONTACT THE BOARD OFFICE.

☐ **JURISPRUDENCE EXAMINATION** –All dental applicants and dental hygiene applicants shall take the online jurisprudence exam at www.nddentalboard.org. Click on Practitioners, scroll down to Application Status, and enter your information. The next page contains the jurisprudence exam. To review for the exam, www.nddentalboard.org/laws-and-rules/index.asp. About three to four weeks prior to the Boards meeting you may receive email from the Executive Director detailing the scheduled time for your interview, if required. Applicants are not required to appear unless notified to appear. The test will shut down after successfully answering a designated number of questions for a passing score. In preparation, see the Laws and Rules tab found on the Board's website.

☐ **REFERENCE FORMS** – Three completed *Confidential Professional Reference* forms are required. References should be from licensed dentists or other professionals who can attest to the applicant's technical skills and professional character. Therefore, references from classmates, friends, relatives, spouses, employees or patients are not accepted by the Board. The reference letters must be returned to the Board by the reference and not the applicant.

☐ **PHYSICAL EXAMINATION** – Submit proof of recent physical on a *Confidential Professional Medical Reference* form provided by the Board. A physical health examination must be within the last 12 months and may be signed by a physician assistant or a nurse practitioner.

☐ **EYE EXAM -** Submit proof of recent eye examination on a *Confidential Professional Medical Reference* form provided by the Board. Eye examination must within the last 12 months.

☐ **VERIFICATION OF LICENSURE** – A license verification form from any state in which you previously held a professional license or currently hold a professional license must be submitted to the NDBDE. Verification must be sent directly to the NDBDE from the state which verifies license or registration attesting that the license was in good standing, or reporting any disciplinary actions. Copies of licenses are not acceptable.

☐ **PROOF OF CONTINUING EDUCATION** – Proof of CE is not required if the application is submitted within 24 months of the completion of the dental program or specialty program. After 24 months of the completion of a dental or dental specialty program a dentist must provide evidence of clinical CE taken within 24 months of application in accordance with Section 20-02-01-06 of the ND Administrative Rules.

☐ **PROOF OF NITROUS OXIDE INHALATION COURSE** – If the nitrous oxide inhalation education/training was not received during the graduate program as indicated by the transcript, proof of a 14 hours of continuing education dealing specifically with the use of nitrous oxide. In the absence of documentation of classroom training, the dentist must provide proof acceptable to the board that demonstrates three years of practical experience in the use of nitrous oxide. CE course is required to administer nitrous oxide inhalation.

☐ **MINIMAL SEDATION, MODERATE SEDATION, DEEP SEDATION AND GENERAL ANESTHESIA REQUIREMENT** – An application, application fee, and documentation must be submitted to the Board prior to providing sedation or general anesthesia.

☐ **PROOF OF ACTIVE PRACTICE and EMPLOYMENT** References may provide verification of dental employment.

☐ **NAME CHANGE DOCUMENTATION** – Submit the name/address change form and attach a copy of a certified document which indicates the reason for a name change.

☐ **CPR** – A photocopy of CPR certification within 24 months of application indicating expiration date. Online CPR must include a 'hands-on' component.

North Dakota Board of Dental Examiners

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Application for Initial Dental License by Examination

Application Fees are Non-refundable

OFFICE USE ONLY - Postmark Date: _____ Date Received _____ Amount _____ Check # _____

North Dakota Century Code § 43-28-11 provides that all license applications and the appropriate fee must be postmarked 30 days prior to the next meeting of the Board. However, supporting documents such as transcripts, references, test scores, verifications and other items may be submitted after the 30 day deadline. Please type or print clearly. It is the responsibility of the applicant to submit all required supporting documents. Once an application has been submitted, the applicant will receive information regarding the criminal background check. The process may take several weeks. Failure to provide supporting documents or submit fingerprint cards in a timely manner may delay licensure. **Note:** The mailing and email address provided will be considered the address of record. It is the applicants' lawful responsibility to maintain current contact information with the Board. Applications must be completed within six months of filing. **Application fees are non refundable.**

License by Examination Fee $440: Applicant has passed within 5 years of application, National Board and approved regional clinical exam. [See Admin. Code 20-02-01-03.1.]

BACKGROUND

Military Status: Are you are a member of OR a spouse of a member of the armed forces of the United States or a reserve component of the armed forces of the United States? ☐ YES ☐ NO
(If yes, please provide proof of military/spouse status, such as military orders or current base ID)

Full Name (First, Middle, Last)		
Maiden Name or Other Names Used		
Social Security Number	Date of Birth	
Home Address	Home Phone	Cell phone
City State		Zip Code + 4
Email Address	DEA number	
Name as you wish it to appear on license (must provide documentation of name change)		
Employer Name		Office Address
City State		Zip Code + 4
Office Phone Number	Office Fax Number	

EDUCATION

Full name of dental school	Location
Degree(s) earned - attach notarized copy of diploma	Date of graduation month/day/year
Other education program	Location
Degree earned	Date of graduation month/day/year

EXAMINATIONS

JCNBE - National Board Dental Examination	Number of attempts _____	Date completed

Name of Board approved regional clinical licensure exams:	Number of attempts _____	Date completed
Other clinical board examinations taken:	Number of attempts _____	Date completed
Certification boards taken:	Number of attempts _____	Date completed

Professional Background (use extra pages if necessary)

Have you been engaged in the clinical practice of dentistry preceding this application? If YES, print the name and address of practice and inclusive dates of employment from the previous 7 years.	YES	NO
	Dates of employment	
	Dates of employment	
	Dates of employment	

CE Requirement: If you answered yes to the above question, you must submit evidence of continuing education. The Board requires 32 hours of CLINICAL CE within two years of application. See complete requirements in the ND Administrative Code 20-02-01-06. You may provide evidence of a maximum of 16 hours of CE by home study or online continuing education. The 32 hour requirement includes CPR and Infection Control credit. Attach photocopy of your current CPR card.

List all jurisdictions in which you have at any time been licensed by a professional licensing board.

License type	**Number**	**State/Jurisdiction**	**Issued**	**Expired**
License type	**Number**	**State/Jurisdiction**	**Issued**	**Expired**
License type	**Number**	**State/Jurisdiction**	**Issued**	**Expired**
License type	**Number**	**State/Jurisdiction**	**Issued**	**Expired**

REFERENCE FORMS – Print names of three references that can attest to your CLINICAL COMPETENCY. Distribute reference forms with a signed copy of your authorization for the reference to release information about your character and competency. References may include professional colleagues, employers, coworkers, or instructors. Do not include spouses, friends, relatives, employees, patients, or fellow students. The reference must return the form directly to the NDBDE.

Reference:	
Address:	**Phone:**
Reference:	
Address:	**Phone**
Reference:	
Address:	**Phone:**

DISCLOSURE

1.	Has there been any investigation or disciplinary action taken against you by a dental school, medical residency or internship program? If YES, attach explanation.	**YES**	**NO**
2.	Have you failed a licensing examination for **any** professional license?	**YES**	**NO**
3.	Has any action ever been taken against hospital or clinical privileges such as a suspension, revocation or any other action? If YES, attach explanation.	**YES**	**NO**
4.	Have you ever had an application for a professional license denied? If YES, provide information on separate attachment.	**YES**	**NO**
5.	Has any disciplinary action ever been instituted which could have affected or could now affect your license to practice in any state? If YES, attach explanation.	**YES**	**NO**
6.	Have you ever held a dental license or certificate in another country?	**YES**	**NO**
7.	Have you ever been subject to informal or formal proceedings by any licensing board, agency, or professional association to revoke, suspend, or limit a professional license? If YES, attach explanation.	**YES**	**NO**

8. Has your license/registration or privileges to practice dentistry ever been suspended, revoked or otherwise disciplined in any state or territory of the United States, or in any foreign country? If "yes", please attach an explanation and provide copies of all judgments, decisions, and agreements?	**YES**	**NO**
9. Have you **ever** been charged or convicted, entered a plea of guilty, no contest, or a similar plea, or had a sentence deferred or suspended in any state or jurisdiction?	**YES**	**NO**
10. Have you ever been found in any civil, administrative or criminal proceeding to have: a. Possessed, used, prescribed for use, or distributed controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes?	**YES**	**No**
b. Been **cited** for operating a motor vehicle while under the influence of drugs or alcohol?	**YES**	**No**
c. Diverted controlled substances or legend drugs?	**YES**	**No**
d. Violated any drug law?	**YES**	**No**
e. Prescribed controlled substances for yourself?	**YES**	**No**

NOTE: If you answered "yes" to the above disclosure questions you must send documentation such as copies of all court documents related to your criminal history with your application. If you do not provide the documents, your application is incomplete and will not be considered. Documentation may also include copy of evaluation and recommendations for treatment if any were issued; a copy of the criminal charges, reported offense, police report and judgment and disposition of criminal complaint; disposition of the offense, final disposition, any orders or any actions pending.

11. Are you now subject to criminal prosecution or pending charges of a crime, felony or misdemeanor in any state or jurisdiction?	**YES**	**No**
12. Do you have criminal charges pending or are you now or have you ever been charged or convicted of any crime, felony or misdemeanor?	**YES**	**No**

NOTE: If you answer "yes" to question (11) or (12), you must explain the nature of the prosecution and/or charge(s). You must include the jurisdiction that is investigating and/or prosecuting the charges. This includes any city, county, state, federal or tribal jurisdiction. If charging documents have been filed with a court, you must provide copies of those documents.

13. Do you have or have you ever had any serious physical or mental illness? If YES please attach explanation.	**YES**	**No**
14. Are you presently engaged in or have you or have you ever been engaged in the excessive use, abuse, addiction to or dependency upon any controlled substance, habit-forming substance or alcohol? If **YES** attach documentation including copy of evaluation and recommendations for treatment if any were issued; a copy of the criminal charges, reported offense, police report and judgment and disposition of criminal complaint; disposition of the offense, final disposition, any orders or any actions pending.	**YES**	**NO**
15. Have you ever been named in any civil suit or suffered any civil judgment for incompetence, negligence or malpractice in connection with the practice of a health care profession? If YES, attach explanation.	**YES**	**NO**
16. Have you ever had **any** malpractice judgment, malpractice settlement, or governmental/private agency disciplinary order issued against you or is there any complaint, malpractice claim, or disciplinary action now pending against you?	**YES**	**NO**

17. Submit a Medical Evaluation and Authorization form completed by a licensed physician or nurse practitioner attesting that you are physically and mentally able to perform the functions of the license you seek and that there are no medical considerations in your health history that might pose a threat to the patients you treat.

18. Submit a Medical Professional Reference form and authorization to a licensed optometrist or ophthalmologist verifying your visual acuity is sufficient for the license you seek.

19. Submit three Confidential Professional Reference forms and authorizations to a colleagues or instructors which may attest to your character and clinical skill. Do not send references from employees, spouse, fellow students, friends or patients.

Nitrous Oxide Inhalation Analgesia: Documentation must be provided that verifies completion of fourteen hours of instruction or continuing education dealing specifically with the use of nitrous oxide inhalation analgesia. Applicants who have successfully completed a training course within the dental program must show proof of nitrous oxide training. Documentation may include class syllabus, course outline or certificate/letter verifying training from the college instructor. Attach any supporting documentation.

Title of Course_____

Location _____ _____

Month/Year

Affidavit of Applicant

Attach Photograph Here
NO STAPLES

For identification purposes, the applicant shall furnish one passport size photograph taken not more than six months prior to the date of application.

Sign your name ***on*** the photo

State of _____)
ss.)
County of _____)

I, _____, the applicant, attest that I have personally filled out this application and am the person referred to in this application for licensure to practice dentistry in North Dakota, and that under penalty of perjury all the information contained in this application and in any attachments or additional documents submitted herewith is true and correct and that all persons and organizations whether public or private, are authorized to release to the North Dakota Board of Dentistry all information, files or records requested in connection with this application.

_____
APPLICANT'S SIGNATURE (Sign before a Notary Public)

Sworn to before me this _____ day of _____ 20 _____

MY commission expires _____

_____
Notary Public Signature

The North Dakota Board of Dental Examiners will carefully review your application for licensure. You may be required to be present for a personal interview. Intentional failure to provide complete information or to fully disclose the answers to the questions posted in this application or concealing relevant information needed by the board for a thorough review of your credentials may constitute fraud and may be considered as the basis for denial of license or revocation of any license which may have been issued to you.

***Practitioners holding a DEA registration:** DEA registrants are required to register and use the Prescription Drug Monitoring Program. **Pursuant to ADMINISTRATIVE RULE 20-02-01-12:** Prior to the initial prescribing of any controlled substance, including samples, a dentist authorized by the drug enforcement administration to prescribe, administer, sign for, dispense, or procure pharmaceuticals shall authorize an employee to review or personally request and review the prescription drug monitoring program report for all available **prescription drug monitoring program** data on the patient within the previous twelve months. **https://www.nodakpharmacy.com/directaccess.asp**

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The North Dakota Board of Dental Examiners CE Reporting Form

Submit this form with documentation of continuing education. Continuing education must be directly related to the clinical practice of dentistry, dental hygiene, or dental assisting. Applicants must provide evidence of 2 hours of infection control and CPR within the previous 24 months. Use this form to list continuing education completed within the previous 24 months of application. Attach all supporting documents. ***If you have graduated from an accredited program within the previous 24 months of application submit proof of current CPR only.***

NAME OF APPLICANT ____

Continuing Education Requirement		
Professional	Hours required	Maximum Online hours accepted
Dentist	32	16
Hygienist	16	8
RDA/QDA	16	8

Date of Course	Title of Course	Description of Course	CE Hours	Location of Course
				Online ☐ Attended lecture ☐ Webinar ☐
				Online ☐ Attended lecture ☐ Webinar ☐
				Online ☐ Attended lecture ☐ Webinar ☐
				Online ☐ Attended lecture ☐ Webinar ☐
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				Online ☐ Attended lecture ☐ Webinar ☐
				Online ☐ Attended lecture ☐ Webinar ☐
				Online ☐ Attended lecture ☐ Webinar ☐
Submit certificates and documentation of CE with this form, print additional pages as required.				

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Medical Evaluation of License Applicant

Dear Doctor, The North Dakota Board of Dental Examiners is conducting a review of the professional credentials of an applicant for a license to practice dentistry or dental hygiene. One of the requirements for licensure is a statement by a licensed physician or nurse practitioner that the applicant has been examined within the last 2 years and found physically and mentally acceptable to engage safely in the practice of dentistry or dental hygiene.

Please document your professional assessment on the form below and send it directly to the Board's address at your earliest convenience. The applicant's authorization for you to provide this information directly to the North Dakota Board of Dental Examiners is provided below.

AUTHORIZATION TO CONDUCT BACKGROUND INVESTIGATION AND MEDICAL EVALUATION

I _____, authorize the NDBDE 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 NDBDE 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 NDBDE 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 NDBDE. 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 base on incomplete, misleading or false information.

Signature of Applicant _____ Date _____

Address of Applicant _____

CONFIDENTIAL PROFESSIONAL REFERENCE AND MEDICAL EVALUATION

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.

OR

☐ I have examined the above named applicant and find the following conditions, which may have an impact on the applicant's ability to safely render health care to patients in the practice of dentistry or dental hygiene.

Comments:

_____
_____
_____
_____

Physician Name (print)

Physician signature

Address Office phone

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Optometric Evaluation of License Applicant

Dear Doctor, The North Dakota Board of Dental Examiners is conducting a review of the professional credentials of an applicant for a license to practice dentistry or dental hygiene. One of the requirements for licensure is a statement by a licensed optometrist or ophthalmologist that the applicant has been examined within the last 2 years and found physically acceptable to engage safely in the practice of dentistry or dental hygiene.

Please document your professional assessment on the form below and send it directly to the Board's address 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.

AUTHORIZATION TO CONDUCT BACKGROUND INVESTIGATION AND MEDICAL EVALUATION

I _____, authorize the NDBDE 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 NDBDE 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 NDBDE 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 NDBDE. 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 base on incomplete, misleading or false information.

Signature of Applicant _____ Date _____

Address of Applicant _____

CONFIDENTIAL PROFESSIONAL REFERENCE AND MEDICAL EVALUATION

Applicant's Name: _____

☐ I have examined the above named applicant and find the applicant's visual acuity is sufficient to permit the safe practice of dentistry or dental hygiene.

OR

☐ I have examined the above named applicant and find the following conditions, which may have an impact on the applicant's ability to safely render health care to patients in the practice of dentistry or dental hygiene.

Comments:

_____

_____

_____

Optometrist Name (print)

Optometrist Signature

Address Office Phone

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Confidential Professional Reference

Dear Doctor or Professional Reference,

The North Dakota Board of Dental Examiners is conducting a review of the professional credentials of an applicant for a license to practice dentistry or dental hygiene. The applicant may not be subject to an actual examination of clinical competency. Among the requirements for licensure are statements by licensed dentists or other professional references that the applicant is judged to be professionally, technically, physically, emotionally and mentally capable of engaging in the practice of dentistry or dental hygiene.

Will you please provide the North Dakota Board of Dental Examiners with your professional assessment of the applicant's fitness to practice dentistry or dental hygiene? Please send the report directly to the North Dakota Board of Dental Examiners at the address above. Please note below the applicant's release below, which enables you to provide whatever information you feel appropriate so that the board can make an informed decision about this applicant. Your information and assistance in this matter is greatly appreciated. The Board appreciates your assistance in this matter and would also like the opportunity to telephone you, should we require any further detail of clarification on any part of the reference your provide.

Sincerely,
Rita Sommers, Executive Director
NDBDE

APPLICANT'S AUTHORIZATION TO CONDUCT BACKGROUND INVESTIGATION AND MEDICAL EVALUATION

I, _____, authorize the North Dakota 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 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 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 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_____ Date _____

Address_____

PRINT 3

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Confidential Professional Reference Evaluation
[This form must be returned to the Board's office by the reference and not the applicant]

Applicant's Name: _____

Please answer each question to the best of your ability and provide whatever comments you feel are appropriate. This form is inappropriate for employees, patients, relatives, or classmates of the applicant.

In what capacity do you know the applicant?
How long have you known the applicant?
How have you observed the professional activity of the applicant?
How would you rate the clinical skills of the applicant?
Are you aware of any problems associated with use of alcohol or drugs?
Are you aware of any malpractice claims or judgment against the applicant?
☐ **I recommend** the applicant for licensure in North Dakota. ☐ **I DO NOT recommend** the applicant for licensure in North Dakota. **Additional Comments:**

_____ _____
PRINT Name Signature Date

_____ ( ) _____|_____
Address Office Phone number Best time to reach

_____
City, State, Zip

PRINT 3

FINGERPRINT CRIMINAL RECORDS CHECK
FOR DENTISTS AND DENTAL HYGIENISTS APPLYING FOR
North Dakota Dental or Dental Hygiene License

DENTAL BOARD FINGERPRINT INFORMATION - Once your application for ND dental or dental hygiene license and license fee have been received by the North Dakota Board of Dental Examiners, two traditional ink fingerprint cards and instructions are mailed to the applicant. Delaying the fingerprinting process may delay your license.

A **North Dakota criminal history record check** is a search of confidential law enforcement databases, cross-referencing by the person's name, date of birth, social security number and other specific identifiers (including fingerprints). The extensive cross-referencing ensures that the result relates only to that person, even if the person has used several names or there are other individuals with the same name. Pursuant to the North Dakota Century Code, only the ND Bureau of Criminal Investigation (BCI) can supply a Criminal History Record Check.

FINGERPRINTS WILL BE USED TO CHECK THE CRIMINAL HISTORY RECORDS OF THE FBI. THE BOARD PROVIDES THE APPLICANT THE OPPORTUNITY TO COMPLETE, OR CHALLENGE THE ACCURACY OF, THE INFORMATION CONTAINED IN THE FBI IDENTIFCATION RECORD. APPLICANTS ARE ADVISED THAT PROCEDURES FOR OBTAINING A CHANGE, CORRECTION, OR UPDATING OF AN FBI IDENTIFICATION RECORD ARE SET FORTH IN TITLE 28, C.F.R., § 16.34. GRANTING OF LICENSURE SHALL NOT BE BASED ON INFORMATION IN THE RECORD UNTIL THE APPLICANT HAS BEEN AFFORDED A REASONABLE TIME TO CORRECT OR COMPLETE THE RECORD, OR HAS DECLINED TO DO SO.

- Applicants may have their fingerprints rolled by a local Law Enforcement Agency or other Board approved agent. Be prepared to pay a fee for having the fingerprint card executed. The fingerprints must be taken by an appropriately trained official. The fingerprint card must be signed by the official in the appropriate block.
- Additional fingerprint cards are available from the Dental Board upon request.
- Ensure that fingerprint cards are completely filled out. Required information includes: Full name, social security number, date of birth, home address, sex, height, weight, hair color, eye color, place of birth etc.
- "**Reason Fingerprinted**" should specify the type of license you are applying for (Dental or Dental Hygiene Licensure)
- Please be advised that if your fingerprint cards are rejected, you will be notified and processing of your application may be delayed. Do not attempt to take your own fingerprints. They will be rejected.
- Mail the fully completed card, along with the fee as instructed on the card to:
  NDBDE, PO Box 7246, Bismarck, ND 58507-7246.

FAILURE TO DISCLOSE CRIMINAL HISTORY

Before you submit any application, please be aware that failure to disclose disciplinary actions, convictions, arrests or charges is grounds for denial or revocation of license. There are no exceptions under which omission of this information in the application or renewal process is deemed acceptable. It should be noted that such information does not automatically disallow licensure. However, disqualification may occur by failing to answer all questions honestly. Read each question on your application carefully.

Examples of past unacceptable explanations provided in "failure to report" incidents to the Board include:

- ⃠ I didn't think I had to mention the DUI because I paid all of the fines.
- ⃠ I didn't think the disciplinary action, arrest, charge, or conviction was still on my record and I was told it was expunged.
- ⃠ My attorney told me I didn't have to disclose the criminal conduct or disciplinary actions.
- ⃠ I didn't think the prior conduct had anything to do with the profession.
- ⃠ I didn't think it was subject to disclosure because I received a deferred sentence/judgment.
- ⃠ I didn't read the question carefully enough.

New license applications and license renewal applications contain questions related to disciplinary actions, illegal or errant behavior and criminal conduct. After receiving a professional license, all license holders continue to be subject to reporting requirements regarding any disciplinary actions, charges or convictions, regardless of in what state they might occur. Please review NDCC § 43-28-18.1. Duty to Report.

VERIFICATION OF DENTAL or DENTAL HYGIENE LICENSE

Please forward one form to each state dental/dental hygiene board where you hold or have ever held a dental/dental hygiene license. Some states require a fee, paid in advance, for providing this information.

I am making application for licensure in North Dakota by:

[ ] Examination for Dental License [ ] Credentials for Dental License
[ ] Examination for Dental Hygiene License [ ] Credentials for Dental Hygiene License
[ ] Reinstatement of ND License [ ] Temporary License

The North Dakota State Board of Dental Examiners requests that I submit evidence that my license is in good standing. You are hereby authorized to release any information in your files, favorable or otherwise directly to:

ATTN: Executive Director
North Dakota Board of Dental Examiners
PO Box 7246
Bismarck, ND 58507-7246

_____ _____
Applicant's Typed/Printed Name Applicant's Signature

_____
Applicant's Address City State Zip+4

Executive Officer of State Board: Please return this form DIRECTLY to the Executive Director

State of _____ Name of Licensee_____

License #_____ Issued_____

By ☐ Reciprocity ☐ Examination ☐ Credential/Endorsement

License is: ☐ Current and Expires on _____ ☐ Active ☐ Inactive ☐ Lapsed-Expired _____/_____/_____

Has applicant's license ever been disciplined, suspended or revoked ☐ NO ☐ YES

If yes, give details and attach supporting documentation (Finding of Fact, Conclusions of Law, Orders):_____

_____

Comments:_____

Signature _____

Title_____

SEAL

Date _____/_____/_____