NORTH DAKOTA BOARD OF DENTAL EXAMINERS
PO Box 7246, Bismarck, ND 58507-7246
www.nddentalboard.org (701) 258-8600

Instruction Checklist for the Application of Temporary Dental License

- **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 recent signed photo to application.

  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to complete all of the requirements for licensure within 6 months from the postmarked date the application and fee are no longer valid [See Section 20-02-01-03.3].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.

- **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 for $40.00 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.

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

- **OFFICIAL TRANSCRIPT** –A FINAL, OFFICIAL 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.

- **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.

- **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.

- **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 ACTIVE PRACTICE and EMPLOYMENT** EVIDENCE of ACTIVE LICENSURE – The applicant must submit evidence of: An active dental license in another jurisdiction; or has held a ND dental license within the previous five years; or, evidence of enrollment in a dental program as a full-time student or resident of a dental program accredited by the American Dental Association's Commission on Dental Accreditation within the last six months; or a resident or full-time student license issued by the dental licensing board.

- **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

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

Application for Temporary Dental License

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

In accordance with ND Administrative Rule 20-02-01-04, the NDBDE may grant a nonrenewable TEMPORARY LICENSE to practice dentistry for a period determined by the Board and not to exceed one year. The Board may apply restrictions as it deems appropriate to limit the scope of practice of dentistry under the authority of the temporary license. It is the responsibility of the applicant to submit all required supporting documents. Once an application and application fee of $250 has been submitted, the applicant will receive information regarding the criminal background check. Failure to provide supporting documents or submit fingerprint cards in a timely manner may delay licensure. Applicants may be required to take the North Dakota online jurisprudence examination.

BACKGROUND			
Full Name (First, Middle, Last)			
Maiden Name or Other Names Used			
Social Security Number	Date of Birth	DEA Number	
Home Address	Home Phone	Cell phone	
City	State		Zip Code + 4
Email Address			
Employer Name	Address		
City	State		Zip Code + 4
Office Phone Number	Office Fax Number		

EDUCATION			
Full Name of Dental School			
Degree Granted	Completion Year	Location	
Other Education/Program		Location	
Specialty		Date of Graduation Month/Day/Year	

EXAMINATIONS	
Date of successful completion of National Board Exam Mo_____/Year_____ Date of successful completion of Clinical Examination Mo_____/Year_____	
Reason for Temporary License request:	Start and end date of event:
Name and address of practitioner or organization that will be assisted by your presence:	Location

PROFESSIONAL BACKGROUND – Use additional 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 5 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. Applicants who have graduated from a dental program within two years are exempt from this requirement. CPR must be maintained at all times. 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 to practice dentistry. Include temporary or resident license.

Jurisdiction	Date Issued	Date Expired	License Number

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. Has any action ever been taken against hospital or clinical privileges such as a suspension, revocation or any other action?	YES	NO
3. Have you ever had an application for a professional license denied? a. If YES, provide information on separate attachment.	YES	NO
4. 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
5. 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? a. If YES, attach explanation.	YES	NO
6. Has your license or clinical/hospital 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
7. 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
8. 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 questions you must send documentation and/or certified 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 includes 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.		
9. Are you now subject to criminal prosecution or pending charges of a crime, felony or misdemeanor in any state or jurisdiction? (provide written explanation)	YES	NO
10. 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
11. Do you have or have you ever had any serious physical or mental illness? If YES please attach explanation.	YES	NO
NOTE: If you answer "yes" to question (10) or (11), 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 certified copies of those documents.		
12. Have you ever held a dental license or certificate in another country?	YES	NO
13. 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
14. 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. The Board may request supporting documents.	YES	NO
15. 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
If you answered "yes" to question (15), explain the nature of the malpractice judgment or settlement. You must include the supporting documents, or copy of the disciplinary order.		
Applicant must attach a photo copy of **DDS/DMD diploma**; a photocopy of a **final transcript** showing date of graduation and degree earned; photocopy of successful results of **national board** [Joint Commission on National Dental Examinations or Canadian National Examining Board]; and evidence of successful completion of a Board approved **clinical examination** [CRDTS, CITA, NERB, WREB, or SRTA].		

Affidavit of Applicant

State of _____)
ss.)
County of _____)

I, _____, the applicant, being first duty sworn, certify that I am the person referred to in this application for licensure to practice dentistry in North Dakota, 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

North Dakota Board of Dental Examiners

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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 ☐
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: _____

☐ 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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FINGERPRINT CARD - CRIMINAL HISTORY RECORDS CHECK

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.

Once your application for ND temporary dental 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.

- 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 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 your fee as instructed on the card to:
  NDBDE, PO Box 7246, Bismarck, ND 58507-7246.