Reinstating Inactive or Expired Licenses

DDS/RDH Reinstatement Applications and the Associated Forms

Once the application and fee have been received by the Board's office the applicant will be sent criminal background check fingerprint cards with instructions. Processing this information may take up to 14 business days. Additional requirements of reinstatement include:

- Dentist: Proof that the dental applicant has completed 32 hours of continuing education in accordance with Administrative Rule § 20-02-01-06 within two years of application. CE must include 2 hours of infection control. Photocopies of certificates of completion are accepted.

- Dental Hygienist: Proof that the dental hygiene applicant has completed 16 hours of continuing education in accordance with Administrative Rule § 20-04-01-08 within two years of application. CE must include 2 hours of infection control. Photocopies of certificates of completion are accepted.

- Proof that the applicant has successfully completed a cardiopulmonary resuscitation course within two years of application. Online CPR courses must include a "hands-on" component. Photocopy of CPR card accepted.

- Grounds for denial of the application under NDCC § 43-28-18 do not exist.

- The applicant must deliver to the board license verification from the examining or licensing board of every jurisdiction in which the individual is or was licensed to practice, certifying that the individual is or was licensed. The license verification form is included in this packet. Some states no longer provide the verification because it is available to the licensee online. A copy of the verification is accepted.

- The applicant provides three completed letters of reference on the *Confidential Professional Reference* forms. References must be from licensed dentists or other professionals of equal or higher educational level, who can attest to the applicant's professional character and technical skills. 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.**

- The applicant provides proof of employment in clinical dental practice (dentist – previous 5 years; hygienist – previous 3 years) or dental education. Examples of proof of employment; W-2's, notarized letter from employer, pay stubs.

- The applicant has passed a written examination on the laws and rules governing the practice of dentistry in this state administered by the board.

- If the applicant intends to provide anesthesia services, a separate application is required. Dental hygienists are not required to have a local anesthesia permit unless they intend to utilize this expanded function. A dentist licensed in ND may not use any form of sedation if the intent is beyond anxiolysis on any patient unless such dentist has a permit currently in effect issued by the Board. Anesthesia services which require a permit:
  - Dental Hygienist: Local anesthesia permit required.
  - Dentist: Minimal, moderate enteral or parenteral sedation, deep sedation and general anesthesia require permit and site evaluation.

- The dentist applicant must provide proof of 14 hours nitrous oxide training or proof demonstrating three years of practical experience in the use of nitrous oxide of as required by Admin. Rule 20-02-01-03.

North Dakota Board of Dental Examiners

PO Box 7246, Bismarck, ND 58507 • Phone 701-258-8600 • Fax 701-224-9824
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2019-2020 Reinstatement Application

☐ **Dentist - fee $400** ☐ **Hygienist - fee $150**

OFFICE USE ONLY: Date Received	Date Completed	Amount	Check #

TYPE OR PRINT LEGIBLY. INCOMPLETE APPLICATIONS WILL BE RETURNED TO THE APPLICANT DELAYING YOUR RENEWAL PROCESS.

Full Name (First, Middle, Last)			Maiden Name	
Name as you wish it to appear on license	Previous ND License Number		Date of Birth	
Circle one: DDS DMD RDH	Year graduated	Name of dental or dental hygiene school		
DEA Number (if applicable)	NPI Number	SSN		
Office/Business Name	Office Phone		Fax	
Office Mailing Address	City		State	Zip
Office Street Address (if different than mailing address)	City		State	Zip
Secondary Office/Business Name (if applicable)	Office Phone		Fax	
Secondary Office Mailing Address	City		State	Zip
Secondary Office Street Address (if different than mailing address)	City		State	Zip
Home Address	City		State	Zip
Home/Cell Phone	Email Address			

1. CPR CERTIFICATION: In accordance with Administrative Rule 20-02-01-06(3), licensees must maintain current CPR certification. Date of your last CPR or BSL course taken within the last 24 months.	**DATE**	
2. INFECTION CONTROL: In accordance with Administrative Rule 20-02-01-06(3), licensees must have two hours of infection control CE biennially. Enter date of last infection control course.	**DATE**	
3. Are you licensed in any other states other than North Dakota? If YES, list states:	**YES**	**NO**
4. Have you submitted a copy of your annual corporate report to the Board? This is the "Professional Corporation Annual Report" showing the owners or shareholders of the incorporated practice. [See NDCC § 43-28-25 (3)]	**YES**	**NO**
5. Dentist: Do you practice as a specialist in one or more ADA recognized specialties? ☐ Dental Public Health ☐ Orthodontics and Dentofacial Orthopedics ☐ Endodontics ☐ Pediatric Dentistry ☐ Oral and Maxillofacial Pathology ☐ Periodontics ☐ Oral and Maxillofacial Radiology ☐ Prosthodontics ☐ Oral and Maxillofacial Surgery ☐ Other (specify):_____	**YES**	**NO**
6. Hygienist: If you intend to utilize the expanded duty of local anesthesia? Please submit the LA application.	**YES**	**NO**
7. Do you perform dentistry utilizing nitrous oxide? *A permit is required when utilizing nitrous oxide with another sedative agent.*	**YES**	**NO**
8. Dentist: If you have a DEA number, have you signed up for the Prescription Drug Monitoring Program as required by ND Administrative Rule 20-02-01-12 and 20-02-01-13? DEA Number _____	**YES**	**NO**

9. Dentist: Do you perform dentistry utilizing conscious sedation or general anesthesia personally administered by you? If YES, submit the permit to administer minimal, moderate conscious sedation, deep sedation or general anesthesia.	**YES**	**NO**

Questions 10 – 17: If you answered "yes" to questions 10 - 17 the Board will require 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. Please send your information directly to the Board. If you do not provide the documents, your application is incomplete and will not be considered. To protect the public, the Board considers criminal history. A criminal history may not automatically bar you from obtaining a credential. However, *failure* to report criminal history may result in extra cost to you and the application may be delayed or denied.

10. Have you **ever** been convicted, entered a plea of guilty, no contest, or a similar plea, or had prosecution or a sentence deferred or suspended in any state or jurisdiction?	**YES**	**NO**
11. Do you have any criminal charges pending against you?	**YES**	**NO**
12. Has there been a malpractice judgment, malpractice settlement, or governmental/private agency disciplinary order issued against you within the last 36 months or is there any complaint, malpractice claim, or disciplinary action, or investigation, now pending against you?	**YES**	**NO**
13. Have you been charged with or convicted of **any** crime, felony, or misdemeanor within the past 36 months?	**YES**	**NO**
14. Have you been cited for operating a motor vehicle while under the influence of drugs or alcohol within the past 36 months?	**YES**	**NO**
15. Are you presently engaged in or have you within the last three years been engaged in the excessive use, abuse, addiction to or dependency upon any controlled substance, habit-forming substance or alcohol?	**YES**	**NO**
16. Have you, in the last 3 years been sanctioned or disciplined by a state licensing or credentialing agency?	**YES**	**NO**
17. Within the last 36 months, has your license to practice dentistry ever been suspended, revoked or otherwise disciplined in any state or territory of the United States, or in any foreign country, related to any anesthesia or sedation incident?	**YES**	**NO**
18. Are there any unsatisfied judgments against you? If YES, attach statement giving amounts, dates and the nature of the judgment, and the reason for non-payment?	**YES**	**NO**
19. Has any action ever been taken against hospital or clinical privileges such as a suspension, revocation or any other action in any state or territory of the United States, or in any foreign country? If YES, please attach explanation and provide copies of all judgments, decisions, and agreements.	**YES**	**NO**
20. Have you ever had an application for a professional license denied? If YES, provide information on separate attachment.	**YES**	**NO**

21. List all jurisdictions in which you have at any time been licensed to practice. Include dates of licensure and license numbers.

Jurisdiction/State	Date issued	License number

22. Provide certification from a licensed optometrist or ophthalmologist or physician that your visual acuity is sufficient for the clinical practice of dentistry/dental hygiene. The form can be printed from the Board's website, www.nddentalboard.org.

23. Provide certification from a licensed physician that you are physically and mentally able to perform the function 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. The form can be printed from the Board's website, www.nddentalboard.org.

24. **Professional References:** Please list the names of three professional references. References should be able to attest to your **clinical skill** and competency. This may include professional colleagues, employers, coworkers, or instructors. **Do not** include friends, spouse, relatives, patients, employees, fellow students or an individual with whom you share a pecuniary interest. Give your references a copy of the reference form with a signed copy of your authorization for them to release information about you. **The person who completed the reference form must send it directly to the North Dakota Board of Dental Examiners.**

Name	Phone
Address	
Name	Phone
Address	
Name	Phone
Address	

Attach photograph here
NO STAPLES

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

Sign your name on the photo.

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 or dental hygiene 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

The North Dakota Board of Dental Examiners will carefully review COMPLETED applications for reinstatement of license. The application will be reviewed by the full Board at their next formal meeting. Meetings are posted on the Boards home page at www.nddentalboard.org. Please note that 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 revocation of any license which may have been issued to you.

Make check payable to NDBDE.
Mail to: NDBDE, PO Box 7246, Bismarck, ND 58507-7246

Voluntary Emergency Response System: The North Dakota State Board of Dental Examiners in cooperation with the North Dakota Emergency Preparedness and Response System is seeking dental volunteers for the North Dakota Public Health Emergency Volunteer Medical Reserve Corps (PHEVR/MRC). Dental professionals who register will be credentialed and offered the opportunity to volunteer on behalf of the State of North Dakota during health and medical emergencies within North Dakota and/or across the country. You may register, or find additional information by contacting the North Dakota Department of Health PHEVR/MRC website www.ndhealth.org/EPR/volunteer. This is not a requirement for licensure.

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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 <u>only</u>. Accepted o***nline CPR must have a **hands-on** component.

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 ☐
				Online ☐ Attended lecture ☐ Webinar ☐
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				Online ☐ Attended lecture ☐ Webinar ☐
				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's Name (print)
Physician's 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

PRINT 3

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Web www.nddentalboard.org • Email info@nddentalboard.org

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

North Dakota Board of Dental Examiners

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Web www.nddentalboard.org • Email info@nddentalboard.org

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

Applicant 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?
As a dental professional with equal or greater education and dental skill, 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 & Credential Signature Date

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

_____
City, State, Zip

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

DENTAL BOARD FINGERPRINT INFORMATION

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 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.

- 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.

North Dakota Board of Dental Examiners

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Web www.nddentalboard.org • Email info@nddentalboard.org

RDH ONLY - Application and Instructions for Local Anesthesia Permit

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

A licensed dental hygienist may apply for a permit to administer local anesthesia to a patient who is at least eighteen years old under the direct supervision of a dentist. Qualified applicants must successfully complete a board approved course within 24 months of application or provide a written statement from the dentist who directly supervised the applicant attesting to experience in administering local anesthesia within the previous three years and provides evidence of a board approved course. See Administrative Rule 20-04-01-03.

TYPE OR PRINT LEGIBLY. INCOMPLETE APPLICATIONS WILL BE RETURNED TO THE APPLICANT DELAYING YOUR REINSTATEMENT PROCESS.		
Full Name (First, Middle, Last)		ND License Number
Address		Home or Cell Phone
City	State	Zip
Work Address		
City	State	Zip
Email		Work phone

LOCAL ANESTHESIA COURSE INFORMATION	
Name of Anesthesia Educational Program/Training Program	
Location of Local Anesthesia Course	
Name of Instructor/Program presenter	Date of Last CPR course
Number of CE credits or college credits	Date Program Completed
Signature	**I certify that I have successfully completed within the last 24 months a didactic and clinical course in local anesthesia, sponsored by a dental or dental hygiene program accredited by the Commission on Dental Accreditation. I submit notarized proof of this course.**
OR	
Signature	**I certify that I have been permitted to administer local anesthesia in another jurisdiction and have continually administered local anesthesia during the past three years and I submit a notarized letter from a licensed dentist to confirm continuous use of local anesthetic and in addition I submit a notarized copy of proof of successful completion of a board approved local anesthesia course.**

Submit with this form:

1. **Notarized copy of anesthesia course certificate of completion**
   OR notarized copy of dental hygiene transcript with L.A. course recorded;
2. **Letter from licensed dentist if required;**
3. **Affidavit of a True Copy**

Note: When a notary makes an attested copy of a document, he/she is not guaranteeing the authenticity of the original document, its contents, or its effects. The notary is simply stating that the document photocopy is a "true" and complete copy of the original document that was presented. The notary's certification is made in a notarial certificate worded expressly for this purpose.

AFFIDAVIT OF A TRUE COPY

State of _____

County of _____

On this _____ day of _____, 20____, I certify that the preceding or attached document is a true, exact, complete and unaltered photocopy made from the original document _____(description of document),
presented to me by _____(name of custodian) and that, to the best of my knowledge, the photocopied document is neither a public record nor a publicly recorded document.

[SEAL] _____
Signature of Notary Public

_____
Printed Name of Notary Public

This space for office use only.

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. Some states may not provide the verification because the information is available to licensees online. The applicant may submit a copy of the online verification in lieu of this form.

I am making application for licensure in North Dakota by:

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

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 _____/_____/_____

2/2019