



North Dakota State Board of Dental Examiners

PO Box 7246, Bismarck, ND 58507-7246 • Phone 701-258-8600

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

APPLICATION FOR DENTAL LICENSE BY EXAMINATION

NON-REFUNDABLE APPLICATION FEE - \$540

REQUIREMENTS FOR LICENSURE

- COMPLETED AND NOTARIZED APPLICATION** - All license applications must include all records required by law, including but not limited to transcripts, references, test scores, verifications of current licenses, and a signed photo taken within 6 months to the application (no staples please).

If you answer YES to questions pertaining to charges, crimes, etc.; the NDSBDE 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 NDSBDE 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 NDSBDE will not return other items sent by the applicant. 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to complete all of the requirements for licensure within 6 months from the postmarked date the application and fee are no longer valid [See Section 20-02-01- 03.3].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.
- MEMBER, OR SPOUSE OF A MEMBER, OF THE ARMED FORCES OF THE UNITED 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 NDSBDE may issue a provisional license or temporary permit not to exceed two years and remains valid while the military member or spouse is making progress toward satisfying the unmet licensure requirements. The applicant must demonstrate competency by standards as issued by the NDSBDE 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 NDSBDE may require an applicant to submit to a statewide and national criminal history record check.
- CRIMINAL BACKGROUND CHECK** – Applicants are required to submit fingerprints and undergo a criminal background check. The appropriate forms may be obtained from a law enforcement agency or a fingerprinting service, or may be requested from the NDSBDE once you submit your application and application fee. Fingerprints 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 Office of the Attorney General. Results shall be received by the NDSBDE prior to the issuance of a license to practice. **FINGERPRINTS WILL BE USED TO CHECK THE CRIMINAL HISTORY RECORDS OF THE FBI. THE NDSBDE PROVIDES THE APPLICANT THE OPPORTUNITY TO CHALLENGE THE ACCURACY OF, THE INFORMATION CONTAINED IN THE FBI IDENTIFICATION 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.**
- DIPLOMA** – submit an 8" x 11" copy.
- OFFICIAL TRANSCRIPT** –A **FINAL** transcript must be sent to the NDSBDE 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 NDSBDE office from the school. (Copies, transcripts that are not in English, unofficial 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 their website to request that an OFFICIAL REPORT of your National Board or Canadian National

Examining Board scores be sent directly to the NDSBDE 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.

- DENTIST CLINICAL EXAM** - Provide evidence of successful completion of an NDSBDE-approved clinical examination taken within five (5) years of application. Required components shall include a periodontal component, posterior composite or amalgam restoration, a class three restorative procedure, and an endodontic component, and after April 1, 2021, a fixed prosthetic component. The NDSBDE accepts all regional clinical exams however the Canadian OSCE exam is not accepted in lieu of the clinical Board requirement. Clinical exams must include a hand skills component.
- 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. The Jurisprudence Examination 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 www.nddentalBoard.org/laws-and-rules/index.asp.
- PHYSICAL EXAMINATION** – Submit proof of recent physical on a *Confidential Professional Medical Reference* form provided by the NDSBDE. 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 NDSBDE. Eye examination must within the last 12 months.
- VERIFICATION OF LICENSURE** – A license verification form from states and jurisdictions in which you currently hold a professional license must be submitted to the NDSBDE. Verification must confirm the license or registration and confirm that the license is in good standing, and reports any disciplinary actions. Verifications can be obtained directly from licensing boards or through online verification tools. Copies of licenses are not acceptable forms of verification.
- 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 an accredited program an applicant must provide evidence of clinical CE taken within 24 months of application in accordance with NDAC 20-02-01-06.
- 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 12 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 NDSBDE that demonstrates three years of practical experience in the use of nitrous oxide. CE course is required to administer nitrous oxide inhalation.
- MODERATE SEDATION, DEEP SEDATION AND GENERAL ANESTHESIA REQUIREMENT** – Sedation may not be provided unless an applicant has been issued a sedation permit by the NDSBDE and has completed an anesthesia site evaluation approved by the NDSBDE.
- PROOF OF ACTIVE PRACTICE and EMPLOYMENT** The applicant, for at least five years immediately preceding application, has been licensed in good standing and has been actively practicing dentistry in another jurisdiction where the requirements are at least substantially equivalent to those of this state.
- 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 State Board of Dental Examiners

PO Box 7246, Bismarck, ND 58502 • Phone 701-258-8600
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Application for Initial Dental License by Examination

Application Fees are Non-refundable - \$40.00

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

Once an application and application fee have been received by the NDSBDE, the applicant may access the Online Ethics and Jurisprudence Examination. Once the fingerprint cards are received, the Bureau of Criminal Investigation will conduct the background check. Their process may take several weeks. Failure to provide supporting documents or submit fingerprint cards in a timely manner may delay the licensing process. **Note:** The mailing and email address provided by the applicant are considered the address of record. It is the applicants' responsibility to maintain current contact information with the NDSBDE. Applications must be completed within six months of filing. **All application fees are non-refundable.** Incomplete applications will be held for up to six months.

License by Examination Fee \$540: 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 and military orders identifying a North Dakota duty station)

| | |
|---------------------------------|--------|
| Full Name (First, Middle, Last) | Gender |
|---------------------------------|--------|

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 5 years. | YES | NO |
| | Dates of employment | |
| | | |
| | Dates of employment | |
| | | |
| | Dates of employment | |
| | | |
| <p>CE Requirement: If you answered yes to the above question, you must submit evidence of continuing education. The NDSBDE requires 32 hours of CLINICAL CE within two years of application. New graduates within two years are exempt. 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 (total) requirement includes CPR and Infection Control credit. Attach photocopy of your current CPR card.</p> | | |
| List all jurisdictions in which you have ever been or are currently licensed by a professional licensing Board. | | |
| License type | DDS/DMD | Number |
| State/Jurisdiction | Issued | Expired |
| License type | DDS/DMD | Number |
| State/Jurisdiction | Issued | Expired |
| License type | DDS/DMD | Number |
| State/Jurisdiction | Issued | Expired |
| License type | DDS/DMD | Number |
| State/Jurisdiction | Issued | Expired |
| 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: | YES | No |
| 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: Criminal history alone is not necessarily a reason for denial of an application or restriction of a license. All facts and circumstances are considered. 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 currently have any physical, mental health, or cognitive condition that impairs your judgement or that would otherwise adversely affect your ability to practice dentistry in a competent and professional manner with reasonable skill and safety? If YES, please attach explanation. <i>If you are engaged with the Professional Health Program available to licensees of the Board, answer NO to this question. NOTE: If you disengage from the PHP without obtaining the PHP's written confirmation that you have fully met the terms of engagement, you must immediately report that disengagement to the Board.</i> | YES | No |
| 14. Do you currently have a condition related to an alcohol or other substance use disorder that would otherwise adversely affect your ability to practice dentistry in a competent and professional manner with reasonable skill and safety? If YES, please attach explanation. <i>If you are engaged with the Professional Health Program available to licensees of the Board, answer NO to this question. NOTE: If you disengage from the PHP without obtaining the PHP's written confirmation that you have fully met the terms of engagement, you must immediately report that disengagement to the Board.</i> | 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 a complete and current Self-Query Report obtained from the National Practitioner Data Bank. | | |



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The North Dakota State 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 |
| Dentist | 32 Total hours: 16 hours may be online self study, the remainder may be webinars or classroom style learning. |
| Dental Hygienist | 16 Total hours: 8 hours may be online self study, the remainder may be webinars or classroom style learning. |
| Registered or Qualified Dental Assistant | 16 Total hours: 8 hours may be online self study, the remainder may be webinars or classroom style learning. |

| Date of Course | Title of Course | Description of Course | CE Hours | Location of Course |
|----------------|-----------------|-----------------------|----------|--|
| | | | | Online self-study course <input type="checkbox"/> Attended lecture <input type="checkbox"/> Webinar <input type="checkbox"/> |
| | | | | Online self-study course <input type="checkbox"/> Attended lecture <input type="checkbox"/> Webinar <input type="checkbox"/> |
| | | | | Online self-study course <input type="checkbox"/> Attended lecture <input type="checkbox"/> Webinar <input type="checkbox"/> |
| | | | | Online self-study course <input type="checkbox"/> Attended lecture <input type="checkbox"/> Webinar <input type="checkbox"/> |
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| | | | | Online self-study course <input type="checkbox"/> Attended lecture <input type="checkbox"/> Webinar <input type="checkbox"/> |
| | | | | Online self-study course <input type="checkbox"/> Attended lecture <input type="checkbox"/> Webinar <input type="checkbox"/> |

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 State Board of Dental Examiners is conducting a review of the professional credentials of an applicant for a license to practice dentistry or dental hygiene. 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 NDSBDE's address at your earliest convenience. The applicant's authorization for you to provide this information directly to the NDSBDE is provided below.

AUTHORIZATION TO CONDUCT BACKGROUND INVESTIGATION AND MEDICAL EVALUATION

I _____, authorize the NDSBDE 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 NDSBDE 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 NDSBDE 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 NDSBDE. 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 State Board of Dental Examiners is conducting a review of the professional credentials of an applicant for a license to practice dentistry or dental hygiene. 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 NDSBDE is provided below.

AUTHORIZATION TO CONDUCT BACKGROUND INVESTIGATION AND MEDICAL EVALUATION

I _____, authorize the NDSBDE 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 NDSBDE 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 NDSBDE 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 NDSBDE. 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

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

DENTAL BOARD FINGERPRINT INFORMATION – Your application for a North Dakota dental or dental hygiene license is not complete until the application fee, and a completed application—including two completed, traditional ink fingerprint cards—are received by the NDSBDE. 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 CHALLENGE THE ACCURACY OF THE INFORMATION CONTAINED IN THE FBI IDENTIFICATION 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 NDSBDE 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:
NDSBDE, 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 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:

- | | |
|---|---|
| <input type="checkbox"/> Examination for Dental License | <input type="checkbox"/> Credentials for Dental License |
| <input type="checkbox"/> Examination for Dental Hygiene License | <input type="checkbox"/> Credentials for Dental Hygiene License |
| <input type="checkbox"/> Reinstatement of ND License | <input type="checkbox"/> 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 _____

Date ____/____/____

SEAL

REVISED 05/02/2025