

Reinstating Inactive License

DDS/RDH Reinstatement Applications and the Associated Forms

Only dentist or hygienist licenses in inactive status may be reinstated. 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.

NATIONAL PRACTITIONER DATA BANK - Submit a personal query from the National Practitioner Data Bank. <https://www.npdb.hrsa.gov/ext/servlet/SQStartInitialServlet>.

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 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:

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 20-02-01-0S{f}{l}.

- ▶ Dental Hygienist: Local anesthesia permit required.
- ▶ Dentist: Moderate sedation, deep sedation and general anesthesia require permit and site evaluation.



North Dakota State Board of Dental Examiners

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

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

REINSTATEMENT APPLICATION

Dentist - fee \$540 Hygienist - fee \$250

OFFICE USE ONLY: Date Received	Date Completed	Amount	Check #
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TYPE OR PRINT LEGIBLY. INCOMPLETE APPLICATIONS WILL BE RETURNED TO THE APPLICANT DELAYING YOUR RENEWAL PROCESS.

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	
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. Dentists Only: Did you submit a copy of your annual corporate report to the Board? This is the "Professional Corporation Annual Report" showing the owners or shareholders of the 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 include the application.			YES NO
7. Do you perform dentistry utilizing nitrous oxide? <i>A permit is required when utilizing nitrous oxide with another sedative agent.</i>			YES NO
8. Dentist: If you have a DEA number, have you signed up for the Prescription Drug Monitoring Program as required by ND			YES NO

Administrative Rule 20-02-01-12 and 20-02-01-13?	DEA Number _____		
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. 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
15. 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
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.

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

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 State 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 State 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 NDSBDE.
Mail to: NDSBDE, 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.

Include with the application evidence 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.



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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. 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. *Accepted online CPR must INCLUDE a hands-on component.*

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.
Permits requiring CE (e.g., anesthesia, restorative, etc.)	Dependent upon permit.

Date of Course	Title of Course	Description of Course	CE Hours	Location of Course
				Online self-study course Attended lecture Webinar
				Online self-study course Attended lecture Webinar
				Online self-study course Attended lecture Webinar
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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 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 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 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 based 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 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 North Dakota State Board of Dental Examiners 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 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 based 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

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 State 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.](#)



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RDH ONLY: Application for Local Anesthesia Permit

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

A registered dental hygienist may apply for a permit to administer local anesthesia. Permit holders may administer local anesthetic to (a) a patient aged 18 and older under the general supervision of a dentist, and (b) to a patient under 18 under indirect supervision of a dentist. See NDAC 20-04.

A \$50.00 application fee must be submitted with this application.

TYPE OR PRINT LEGIBLY. INCOMPLETE APPLICATIONS WILL BE RETURNED TO THE APPLICANT.	
Full Name (First, Middle, Last)	ND License Number
Address	Cell Phone
City	State Zip
Work Address	
City	State Zip
Email	Home Phone
LOCAL ANESTHESIA COURSE INFORMATION	
Name of Anesthesia 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
<input type="checkbox"/> I certify that within the last five years, I have successfully completed a didactic and clinical course in local anesthesia sponsored by a dental or dental hygiene program accredited by the commission on dental accreditation of the American dental association resulting in the dental hygienist becoming clinically competent in the administration of local anesthesia Applicant Signature:	
OR	
<input type="checkbox"/> I certify that I have been authorized to administer local anesthesia in another jurisdiction and am providing verification that I have demonstrated clinical competency during the previous five years. Verification may consist of either: (a) a letter from the accredited school with the school seal affixed (photocopies not accepted), (b) a notarized copy of the certification of the local anesthesia course, or (c) a notarized letter from a licensed dentist stating the licensed dental hygienist has competently administered local anesthesia. Applicant Signature:	
Print name of dentist attesting to continuous use of local anesthesia:	Office Phone
Work Address	
City	State Zip

Submit with this form:

1. **Notarized copy of anesthesia course certificate of completion OR notarized copy of dental hygiene transcript with course recorded;**
2. **Verification of clinical competency materials;**
3. **Affidavit of a True Copy; and**
4. **Application Fee**

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.