North Dakota State Board of Dental Examiners

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

APPLICATION FOR LICENSE BY CREDENTIAL REVIEW

Instructions/Check list	
Dentist Nonrefundable Fees **Application: $1490** **Professional Health Program: $75.00**	**Hygienist Nonrefundable Fees** **Application $560**

- **COMPLETED AND NOTARIZED APPLICATION** – Please submit all required information. If you answered "yes" to any question that requires an explanation..

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to complete all of the requirements for licensure within 6 months from the postmarked date the application and fee are no longer valid [See Section 20-02-01-03.3].

- **CRIMINAL BACKGROUND CHECK** – Applicants are required to submit fingerprints and undergo a criminal background check. The appropriate forms will be sent to the applicant upon receipt of application and application fee. Return the fingerprint forms which may be completed by local law enforcement or fingerprinting service center which may take digital prints. Submit both fingerprint cards to the NDSBDE with your check or money order payable to the ND Attorney General. The process may take up to ten days. Results shall be received by the Board prior to the issuance of a license to practice. Check with local law enforcement for scheduling.

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

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

- **OFFICIAL TRANSCRIPT** – Submit a FINAL, OFFICIAL transcript of dental/dental hygiene education. This transcript must be sent to the ND Board office by the school and must show the date of graduation, the degree earned, and have the seal of the school. It is the applicant's responsibility to arrange to have the transcript mailed directly to the board office from the school. (Copies, student transcripts or incomplete transcripts are not acceptable.)

- **NATIONAL BOARD RESULTS** - Provide a *notarized* copy of successful National Board results. Alternatively, you may contact the ADA to order your National Board Score Report and request that it be sent directly to the NDSBDE. To order your report, go to www.ada.org, click **EDUCATION/CAREERS**, click **DENTPIN**. From here, you can register or retrieve your DENTPIN#. Once you have a DENTPIN# and your password, scroll down to the bottom of the DENTPIN page and click **Send Official Score/Result Reports** to see the listing of available reports. Dentists will need to choose "National Board Dental Exam (NBDE Part1/Part II)". Hygienists will need to choose "National Board Dental Hygiene Exam (NBDHE)". Bypass the state dropdown and have your scores emailed **directly to: info@nddentalboard.org. If you have any questions while attempting to order your score report, please contact the** ADA directly at 800-232-1694.

- **CLINICAL EXAM RESULT** - Provide evidence of having passed a Board approved clinical examination given by a regional testing service. The Board accepts all dental regional clinical exams and most dental hygiene regional clinical board exams. If the applicant has not taken a board approved clinical exam, the onus falls on the applicant to provide evidence that the clinical examination is substantially equivalent to the clinical exams accepted by the Board [see ND Administrative Code 20-02-01-03.1 for dentist or for dental hygienists, ND Administrative Code 20-04-01-05].

- **JURISPRUDENCE EXAMINATION** – The ND jurisprudence exam is offered at some dental hygiene programs to dental hygiene graduates. Once the application and application fee are received by the Board's office, an applicant may take the open book online JP exam. A fee is not required to take the exam. Two hours of CE are awarded upon successful completion of the online exam.

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

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

- **VERIFICATION OF LICENSURE –** The applicant has delivered to the NDSBDE a certificate from the examining board or licensing board of every jurisdiction in which the individual is licensed to practice, certifying that the individual is a licensed and registered dental hygienist in good standing in that jurisdiction.

- **PROOF OF CONTINUING EDUCATION** – Proof of CE is not required if the application is submitted within 24 months of the completion of the dental program or specialty program. *After* 24 months of the completion of a dental program or specialty program, a dentist must provide evidence of thirty-two hours of continuing education in accordance with Section 20-02-01-06 taken within 2 years of application. A hygienist must provide evidence of sixteen hours of continuing education in accordance with Section 20-02-01-06 taken within 2 years of application.

- **PROOF OF NITROUS OXIDE INHALATION COURSE** – The Board may issue a permit authorizing the administration of nitrous oxide inhalation to a dentist or dental hygienist or registered dental assistant if requirements are met. See ND 20-02-01-05(1). In the absence of documentation of classroom training, the practitioner must provide proof acceptable to the Board that demonstrates three years of practical experience in the use of nitrous oxide. A dentist or hygienist must have Basic Life Support certification to administer nitrous oxide inhalation analgesia.

- **MODERATE SEDATION, DEEP SEDATION AND GENERAL ANESTHESIA REQUIREMENT** – An application, application fee, and documentation for a permit to administer anesthesia or sedation may be submitted at the time of initial licensure or a later date. The application is not a requirement of licensure unless you intend to provide sedation/anesthesia services and if the intent is beyond minimal sedation.

- **NOTARIZED AFFIDAVIT FOR PROOF OF CLINICAL PRACTICE and EMPLOYMENT - DENTIST -** License by Credential applicants must submit proof that for at least five years immediately preceding application, applicant has been 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. **DENTAL HYGIENIST** License by Credential applicants must submit proof that for at least three years immediately preceding application applicant has been licensed in good standing and has been actively practicing dental hygiene in another jurisdiction where the requirements are at least substantially equivalent to those of this state. Licensee must provide employment verification. Copies of W-2 acceptable.

- **NAME CHANGE DOCUMENTATION** – Submit a copy of a certified document which indicates the reason for a name change.

- **C P R** – A photocopy of CPR certification within 24 months of application indicating expiration date. Online CPR courses must have a "hands-on" component.

- **MAILING ADDRESS** – *During the application process* the Board will send all correspondence to the current email address or home address.

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Application for License by Credential

OFFICE USE ONLY - Postmark Date: _____Date Received _____Amount _____Check # _____

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

BACKGROUND		
Full Name (First, Middle, Last)		
Maiden Name or Other Names Used	Name as you wish it to appear on certificate of license	
Social Security Number	Date of Birth	Gender
Home Address		
City State		Zip Code + 4
Email Address		DEA number(s) issued
Employer Name	Office Address	
City State		Zip Code + 4
Office Phone Number	Mobile phone number where you can best be reached	
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)		

DENTAL EDUCATION	
Full Name of Dental or Dental Hygiene School	
Degree granted (attach notarized copy of diploma)	Date of Graduation month/day/year
Name of Post-Graduate Dental Institution	
Specialty	Enrollment Dates:

EXAMINATION HISTORY	
National Board Examination Part I	Date Completed
National Board Examination Part II	

Dental Hygiene National Board Examination	Dates Completed
Attach notarized copy of regional clinical board examinations:	

PROFESSIONAL BACKGROUND – Use additional pages if necessary**.**
Have you been engaged in the active clinical practice of dentistry preceding this application? If YES, PRINT name and address of practice and inclusive date of employment from the previous 7 years. YES _____ NO _____

	Dates of employment
	Dates of employment
	Dates of employment

List ALL jurisdictions in which you have ever held a professional license at any time.

Jurisdiction	Date Issued	Date Expired	License Number

DISCLOSURE

1. Has there been any investigation or disciplinary action taken against you by a dental school, medical residency or internship program? If YES, attach explanation.	**YES**	**NO**
2. 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 or dental hygiene license or certificate in another country?	**YES**	**NO**
7. Have you ever been subject to informal or formal proceedings by any licensing board, agency, or professional association to revoke, suspend, or limit a professional license? If YES, attach explanation.	**YES**	**NO**
8. Has your license/registration or privileges to practice dentistry ever been suspended, revoked or otherwise disciplined in any state or territory of the United States, or in any foreign country? If "yes", please attach an explanation and provide copies of all judgments, decisions, and agreements?	**YES**	**NO**
9. Have you *ever* been charged or convicted, entered a plea of guilty, no contest, or a similar plea, or had a sentence deferred or suspended in any state or jurisdiction?	**YES**	**NO**

10. Have you ever been found in any civil, administrative or criminal proceeding to have: a. Possessed, used, prescribed for use, or distributed controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes?	**YES**	**No**
b. Been *cited* for operating a motor vehicle while under the influence of drugs or alcohol?	**YES**	**No**
c. Diverted controlled substances or legend drugs?	**YES**	**No**
d. Violated any drug law?	**YES**	**No**
e. Prescribed controlled substances for yourself?	**YES**	**No**
NOTE: If you answered "yes" to the above questions you must send documentation such as certified copies of all court documents related to your criminal history with your application. If you do not provide the documents, your application is incomplete. 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 certified 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 in a competent and professional manner with reasonable skill and safety? If YES, please attach explanation. *If you are a dentist applicant 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.*	**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 in a competent and professional manner with reasonable skill and safety? If YES, please attach explanation. *If you are a dentist applicant 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.*	**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.		

Nitrous Oxide Inhalation Analgesia: Documentation must be provided that verifies completion of twelve hours of instruction or continuing education dealing specifically with the use of nitrous oxide inhalation analgesia. Applicants who have successfully completed a training course within the accredited program must show proof of nitrous oxide training. Documentation may include class syllabus, course outline or certificate/letter verifying training from the college instructor. Attach any supporting documentation. [See NDAC § 20-02-01-05(1)]. If the course was completed more than thirteen months before application, and applicant has legally administered nitrous oxide inhalation analgesia for a period during the three years preceding application, the applicant must provide written documentation from a dentist that has employed the applicant or a statement attesting to the current clinical proficiency of the applicant to administer nitrous oxide inhalation analgesia.

_____ _____

Name and location of course Month/Year

Affidavit of Applicant

State of _____)
ss)
County of _____)

Paste Photograph taken Within the last 6 months Here

or photocopy of current drivers license.

I, _____, the applicant, being first duty sworn, certify that I am the person referred to in this application for licensure to practice 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 Dental Examiners all information, files or records requested in connection with this application.

Sign your name on the photo

_____

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 your application for licensure. You may be required to be present for a personal interview and take an examination on the Rules of the Board and the North Dakota Dental Practice Act. 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 denial of license or revocation of any license which may have been issued to you.

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The North Dakota State Board of Dental Examiners CE Reporting Form

Submit this form with printed 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 CE and CPR certification within the previous 24 months. Use this form to list continuing education completed within the previous 24 months of application and attach supporting documents of completed CE (webinar courses must indicate 'webinar' on the certificate). If you have graduated from an accredited program within the previous 24 months of application submit proof of current CPR only. CPR courses must have 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.
Registered or Qualified Dental Assistant	16 Total hours: 8 hours may be online self study, the remainder may be webinars or classroom style learning.

Name (print):		**DDS/DMD ☐**	**RDH ☐**	**RDA/QDA ☐**
Date of Course	Title of Course	Description of Course	CE Hours	Location of Course
				Online ☐ Webinar ☐ Attended lecture ☐
				Online ☐ Webinar ☐ Attended lecture ☐
				Online ☐ Webinar ☐ Attended lecture ☐
				Online ☐ Webinar ☐ Attended lecture ☐
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Medical Evaluation of License Applicant

Dear Doctor, The North Dakota State Board of Dental Examiners (NDSBDE) is conducting a review of the professional credentials of an applicant for a license to practice dentistry or dental hygiene in the State of North Dakota. 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 12 months 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 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 (NDSBDE) is conducting a review of the professional credentials of an applicant for a license to practice dentistry or dental hygiene in the State of North Dakota. One of the requirements for licensure is a statement by a licensed optometrist or ophthalmologist that the applicant has been examined within the last 12 months 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 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 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 Licensure)
- Please be advised that if your fingerprint cards are rejected, you will be notified and processing of your application may be delayed. Do not attempt to take your own fingerprints. They will be rejected.
- Mail the fully completed card, along with your fee as instructed on the card to:
  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.

NOTARIZED AFFIDAVIT FOR PROOF OF CLINICAL PRACTICE

Applicant: _____

This Affidavit MUST NOT be completed by the applicant, any person who is an employee or relative of the applicant, or an entity who currently has a fee for service relationship with the applicant.

Please print legibly or type.

I, _____, the undersigned, do of my own personal knowledge make the following statements and declare them to be true. That:

1. My profession is _____.
2. I have known _____, the applicant, for the last _____years.
3. I am not a relative or an employee of the applicant, nor am I an entity who currently has a fee for service relationship with the applicant.
4. I have knowledge of the applicant's active clinical dental practice during the last five (5) years, and his/her current clinical competency,

   OR;

   I have knowledge of the applicant's active clinical dental hygiene practice during the last three (3) years, and his/her current clinical competency, because;

   _____

   _____

   _____
5. The following address and phone number is the most current and valid for me to be reached for further verification of any information relating to this affidavit:

Address	City	State	Zip
Phone	Ext.		

Signed by my own hand and sworn to on this

the _____day of _____20_____

_____

Signature of Affiant

SUBSCRIBED AND SWORN to before me

this _____day of _____20_____

_____

Notary

My Commission Expires ____/____/20_____

INCOMPLETE AFFIDAVITS OR AFFIDAVITS NOT NOTARIZED CANNOT BE ACCEPTED. DO NOT RETURN COMPLETED FORM TO APPLICANT. MAIL COMPLETED, NOTARIZED FORM TO:

NDSBDE
PO BOX 7246
BISMARCK, ND 58507-7246

VERIFICATION OF DENTAL or DENTAL HYGIENE LICENSE

Please forward one form to each state dental/dental hygiene licensing board where you hold a dental/dental hygiene license. Some states require a fee, paid in advance, for providing this information. Other states forms are accepted.

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 State 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, North Dakota State Board of Dental Examiners.

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 ____/____/____

Revised 11/01/2024