



STATE OF IOWA

IOWA DENTAL BOARD

TERRY E. BRANSTAD, GOVERNOR
KIM REYNOLDS, LT. GOVERNOR

JILL STUECKER
EXECUTIVE DIRECTOR

Iowa Dental License Application

Application Form and Fee

Please find enclosed the application for Iowa dental license. When completing this application, please be advised of the following:

- The application fee is non-refundable. Do not submit payment in cash.
- For specific license requirements, please refer to the Board's rules at Iowa Administrative Code 650—Chapter 11.
- Type or legibly print all information requested in the application. Complete all questions. If not applicable, please mark sections 'N/A'.
- Licenses are issued administratively following review of a completed application and all required documentation, unless the application warrants referral to the Licensure/Registration Committee, the full Board, or unless a personal appearance is required.
- Applications are valid for only 180 days from the date of receipt. If the application has not been completed within 180 days, a new application and fee will have to be submitted if you wish to obtain an Iowa dental license.
- **Failure to answer all questions completely or accurately, and/or omission or falsification of material facts may be cause for denial of your application, or disciplinary action if you are subsequently licensed by the Board.**
- Dentists licensed in the state of Iowa cannot administer deep sedation/general anesthesia or moderate sedation in the practice of dentistry unless a separate permit has been obtained from the Iowa Dental Board. You may download the applications for moderate sedation or general anesthesia permits at <http://www.dentalboard.iowa.gov/forms.html>, or you may contact the Board office.

Basis of Application

Licensure by Examination: If you completed the Central Regional Dental Testing Service, Inc. (CRDTS) examination within five years of the date of application, or if you successfully completed the Western Regional Examination Board, Inc. (WREB) or the American Board of Dental Examiners, Inc. (ADEX) examinations in the five years prior to September 1, 2011, you are eligible to apply for a dental license on the basis of examination.

The fees due for application on the basis of examination, including the background check fee, are \$246.

Licensure by Credentials: If you have obtained a dental license in another state, district or territory of the United States on the basis of examination (e.g. CRDTS, WREB, SRTA, or ADEX), or if you have been licensed and practicing in another state for a minimum of three consecutive years immediately prior to the date of application, you are eligible to apply for a dental license on the basis of credentials.

The fees due for application on the basis of credentials, including the background check fee, are \$596.

Public Information

All or part of the information provided on the application form may be considered a public record under Iowa Code Chapter 22 and Iowa Administrative Code 650—Chapter 6. Information about misconduct and examination results may not be subject to disclosure.

Disclosure of Medical Conditions, Criminal History, Disciplinary Actions and Malpractice Claims

Be advised that the application for dental license asks about any medical conditions you have that might impair your ability to practice the profession. The Board also considers any prior criminal history, disciplinary actions and malpractice claims when issuing dental licenses. As part of the application process you will be asked questions about prior criminal history, disciplinary action, and malpractice claims.

If you have any questions concerning these requirements, please notify the Board office. If any of these situations pertain to you, there may be delays at the time of licensure. We suggest you contact the Board office for information as to what documentation may be necessary for licensure. Contacting the Board office about any of these situations may avoid unnecessary delays at the time of licensure.

The Iowa Dental Board will provide you with a packet of information necessary to perform a criminal history background check as required by Iowa Administrative Code 650—Chapter 11. The Board will not issue a license until you have returned the completed packet and fee for the criminal history background check to the Board office. Please make sure that the information and the fingerprints you provide in the criminal history background check packet are legible. In the event the fingerprints are rejected by the DCI or FBI, you will be required to submit a new fingerprint packet and fee.

You will need to submit a copy of the results of a self-query of the National Practitioner Data Base (NPDB) and the Healthcare Integrity and Protection Data Bank (HIPDB). You may request the self-query at <https://www.npdb.hrsa.gov/ext/selfquery/SQHome.jsp>.

Military Service & Veterans Preference: Pursuant to the 2014 Home Base Iowa Act, if you are currently serving in the military or are a veteran, you may be eligible to request credit towards licensure for verified military education, training, or service toward licensing experience or education requirements by submitting a (separate) military service application form to the Board office. Please contact Board staff at 515-281-5157 for further information or to obtain military service application form.

Veterans who have a fully completed application for licensure will be given priority and will be expedited. Veterans who hold an unrestricted professional license in another jurisdiction may be eligible for licensure through reciprocity.

Military Service: “Military service” means honorably serving on federal active duty, state active duty, or national guard duty, as defined in Iowa Code section 29A.1, in the military services of other states, as provided in 10 U.S.C. section 101(c), or in the organized reserves of the United States, as provided in 10 U.S.C. section 10101.

Veteran: A “veteran” means an individual who meets the definition of “veteran” in Iowa Code section 35.1(2).

Spouse of Veteran: A “spouse of a veteran” means a spouse of a qualified veteran.

Jurisprudence Examination

After you have submitted your application to the Board office, the Board will provide you authorization to sit for the jurisprudence examination. Successfully complete the Iowa jurisprudence examination, which is based on information contained in Iowa Code chapters 147, 153, 272C, and 650 Iowa Administrative Code. Study materials are located at <http://www.dentalboard.iowa.gov/board/rules-policy/index.html>. Review Iowa Administrative Code 650 and the Code of Iowa chapters. To take the examination, make arrangements directly with one of the Iowa community college testing sites. A proctor fee will be paid directly to the community college testing site.

Graduates of Foreign Dental Schools

In addition to meeting the other requirements for licensure specified in rule 650—11.2(147,153) or 650—11.3(153), an applicant for dental licensure who did not graduate with a DDS or DMD from an ADA-accredited dental college approved by the Board must provide evidence of having met all requirements as set forth in rule 650—11.4(153).

Testing Sites

A list of testing sites is available at <http://www.dentalboard.iowa.gov/forms/docs/TestingSites.pdf>.

National Practitioner Data Banks (NPDB) and the Healthcare Integrity and Protection Data Bank (HIPDB)

To perform a self-query: <https://www.npdb.hrsa.gov/ext/selfquery/SQHome.jsp>

Contact Us

If you have any questions, or need further assistance, please feel free to contact the office at IDB@iowa.gov, or Teleza “TJ” Daniels at 515-281-5047, or Christel Braness at 515-242-6369.

Board rules and Iowa Code chapters: <http://www.dentalboard.iowa.gov/board/rules-policy/index.html>.

Board website: www.dentalboard.iowa.gov

Application Checklist

<input type="checkbox"/>	Application completely filled out; all questions answered.
<input type="checkbox"/>	Application & background check fees paid. (\$246 by examination; \$596 by credentials)
<input type="checkbox"/>	Notarized copy of marriage certificate or divorce decree (if applicant's name is different on application and documents)
<input type="checkbox"/>	Affidavit of Applicant
<input type="checkbox"/>	Completed certifications: <ul style="list-style-type: none"> ▪ Fees are non-refundable; ▪ Use of moderate sedation and/or general anesthesia; ▪ Public Information – Iowa Code Chapter 22 & IAC 650—Chapter 6; ▪ Licenses issued administratively unless applicant warrants further review and/or referral; and ▪ Applications valid for 180 days.
<input type="checkbox"/>	For each “Yes” answer to questions 1 through 22, you must provide a separate, signed statement giving full details, including date(s), location(s), action(s), organization(s) or parties involved, and specific reason(s).
<input type="checkbox"/>	Authorization to Release Information (signed and dated)
<input type="checkbox"/>	Applicant's Letter to IA Dental Board including the following: <ul style="list-style-type: none"> ▪ Reason why you wish to be licensed in Iowa; ▪ Your practice plans, if known; ▪ Whether you intend to <i>dispense</i> controlled substances as part of your practice; ▪ Whether you intend to provide moderate sedation and/or general anesthesia as part of your practice. Please be as specific as possible.
<input type="checkbox"/>	Certification of Education (from accredited school, signed & dated, w/school seal)
<input type="checkbox"/>	CPR Certification: Copy of CPR card, <u>OR</u> a statement confirming that the applicant possesses a valid certificate from a nationally-recognized course in CPR that includes a “hands-on” clinical component, includes the date of expiration and acknowledges that proof of certification will be maintained and made available to the Board upon request.
<input type="checkbox"/>	Copy of clinical examination scores. An applicant is exempt from this requirement if applying on the <u>basis of credentials</u> and the applicant has lawfully been in practice for 5 or more years in another state or territory. (See IAC 650—11.3(2)c)
<input type="checkbox"/>	Copy of documentation verifying prior-approved remedial education (if more than 2 exam failures)
<input type="checkbox"/>	National Board card w/ scores. Original or copy. An applicant is exempt from this requirement if applying on the <u>basis of credentials</u> and the applicant has lawfully been in practice for 5 or more years in another state or territory. (See IAC 650—11.3(2)b)
<input type="checkbox"/>	License certification from each state where applicant has been licensed.
<input type="checkbox"/>	Copy of results of NPDB/HIPDB self-query.
<i>Additional Special Attachments if Graduate of Foreign School:</i>	
<input type="checkbox"/>	Copy (notarized) of accredited dental school diploma, degree, or certificate
<input type="checkbox"/>	Copy of transcript from accredited dental school that verifies completion of coursework (except for approved waiver applicants)
<input type="checkbox"/>	Letter from dean or certificate of education from accredited school verifying applicant completed requirements (except for approved waiver applicants)
<input type="checkbox"/>	Copy of transcript from foreign dental school verifying graduation from foreign dental school
<input type="checkbox"/>	Notarized translation of transcript, if applicable
<input type="checkbox"/>	Copy of scores verifying English proficiency <ul style="list-style-type: none"> <input type="checkbox"/> TOEFL score of 550 for paper exam or 213 on computer exam; <input type="checkbox"/> TSE of at least 50



APPLICATION FOR IOWA DENTAL LICENSE

IOWA DENTAL BOARD

400 S.W. 8th Street, Suite D, Des Moines, Iowa 50309-4687

Ph. (515) 281-5157 <http://www.dentalboard.iowa.gov>

Application by Examination

Application by Credentials

This form must be completed and returned to the Iowa Dental Board. Include the *non-refundable* application fee. Do not submit payment in cash. Complete each question on the application. If not applicable, mark "N/A."

Full Legal Name: (First, Middle, Last)				
Other Names Used: (e.g. Maiden Name)			Email Address:	
Home Address:			Home Phone:	
City:	County:	State:	Zip Code:	
Date of Birth:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	U.S. citizen: <input type="checkbox"/> Yes <input type="checkbox"/> No	If no, visa type or alien registration number: <input type="checkbox"/> Student Visa <input type="checkbox"/> Work Visa <input type="checkbox"/> Alien Registration Provide visa or alien registration number: If visa, provide expiration date of current visa:	
Social Security #:	Privacy Act Notice: Disclosure of your Social Security Number on this registration application is required by 42 U.S.C. § 666(a)(13), Iowa Code §§ 272J.8(1) and 261.126(1), and Iowa Code § 272D.8(1). The number will be used in connection with the collection of child support obligations, college student loan obligations, and debts owed to the state of Iowa, and as an internal means to accurately identify registrations, and may also be shared with taxing authorities as allowed by law including Iowa Code § 421.18.			
City of Birth:	State of Birth:	Country of Birth:		
Work Address:	Work Phone:	Work Fax:		
City:	County:	State:	Zip:	Work Email:
Are you currently serving in the military? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are you a Veteran? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are you the spouse of a Veteran? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are you currently certified in CPR? <input type="checkbox"/> Yes <input type="checkbox"/> No	CPR Expiration Date:

EDUCATION

Please provide information about all of your education. Please use an additional sheet of paper if necessary.

Institution	City, State, Country	From (Mo/Yr)	To (Mo/Yr)	Degree/Diploma Received
Dental School:				
High School:				
College:				
Other:				

For office use only:	License #:	Date Issued:	Fees (App/Fprint):
-----------------------------	-------------------	---------------------	---------------------------

Name of Applicant: _____

PRACTICE INFORMATION

Primary Practice Setting: <input type="checkbox"/> Educational <input type="checkbox"/> Group <input type="checkbox"/> Military <input type="checkbox"/> Public Health <input type="checkbox"/> Solo <input type="checkbox"/> Other:		Practice at more than 1 location? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, where:		Practice Status: <input type="checkbox"/> Full Time <input type="checkbox"/> New Applicant <input type="checkbox"/> Not Practicing <input type="checkbox"/> Part Time <input type="checkbox"/> Temporarily Inactive <input type="checkbox"/> Retired	
Do you intend to administer nitrous oxide? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you intend to administer moderate sedation? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you intend to administer general anesthesia? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you intend to <i>dispense</i> controlled substances? <input type="checkbox"/> Yes <input type="checkbox"/> No		

What are your intended practice plans and reason for seeking licensure in Iowa? _____

SPECIALTY INFORMATION

Primary Specialty (if applicable): <input type="checkbox"/> Dental Public Health <input type="checkbox"/> Endodontics <input type="checkbox"/> General Practice <input type="checkbox"/> Operative Dentistry <input type="checkbox"/> Oral/Max Pathology <input type="checkbox"/> Oral/Max Radiology		<input type="checkbox"/> Oral/Max Surgery <input type="checkbox"/> Orthodontics <input type="checkbox"/> Pediatrics <input type="checkbox"/> Periodontics <input type="checkbox"/> Prosthodontics		Are you board certified? <input type="checkbox"/> Yes <input type="checkbox"/> No	Type of training: <input type="checkbox"/> Intern <input type="checkbox"/> Resident <input type="checkbox"/> Fellow <input type="checkbox"/> Other (Be Specific): _____
Secondary Specialty (if applicable): <input type="checkbox"/> Dental Public Health <input type="checkbox"/> Endodontics <input type="checkbox"/> General Practice <input type="checkbox"/> Operative Dentistry <input type="checkbox"/> Oral/Max Pathology <input type="checkbox"/> Oral/Max Radiology		<input type="checkbox"/> Oral/Max Surgery <input type="checkbox"/> Orthodontics <input type="checkbox"/> Pediatrics <input type="checkbox"/> Periodontics <input type="checkbox"/> Prosthodontics		Are you board certified? <input type="checkbox"/> Yes <input type="checkbox"/> No	Type of training: <input type="checkbox"/> Intern <input type="checkbox"/> Resident <input type="checkbox"/> Fellow <input type="checkbox"/> Other (Be Specific): _____

EXAMINATION INFORMATION

List all national, regional, or state licensure exams you have taken. Include the date and indicate if you passed or failed. Add additional sheets if necessary.

National Board (written):	Date:	<input type="checkbox"/> Pass <input type="checkbox"/> Fail
Clinical Board (e.g. CRDTS, WREB, ADEX, or SRTA):	Date:	<input type="checkbox"/> Pass <input type="checkbox"/> Fail
Jurisprudence (Iowa) if completed prior to application:	Date:	<input type="checkbox"/> Pass <input type="checkbox"/> Fail
Other:	Date:	<input type="checkbox"/> Pass <input type="checkbox"/> Fail

Name of Applicant: _____

CHRONOLOGY OF ACTIVITIES

Provide a chronological listing of all dental and non-dental activities for the last 5 years, or from the date of your graduation from dental school to the present date, with no more than a three (3) month gap in time. Include months, years, location (city & state), and type of practice. Attach additional sheets of paper, if necessary, labeled with your name and signed by you.

Activity & Location	From (Mo/Yr):	To (Mo/Yr):

LICENSE INFORMATION

List all state/countries in which you are or have ever been licensed. Please note: you will be required to request written certifications of all licenses.

State/Country	License No.	Date Issued	License Type (e.g. Permanent, Resident, Faculty)	How Obtained (e.g. Credentials, Exam)

DEFINITIONS

Important! Read these definitions before completing the following questions.

“Ability to practice dentistry with reasonable skill and safety” means ALL of the following:

1. The cognitive capacity to make appropriate clinical diagnosis, exercise reasoned clinical judgments, and to learn and keep abreast of clinical developments;
2. The ability to communicate clinical judgments and information to patients and other health care providers; and
3. The capability to perform clinical tasks such as dental examinations and dental surgical procedures.

“Medical condition” means any physiological, mental, or psychological condition, impairment, or disorder, including drug addiction and alcoholism.

“Chemical substances” means alcohol, legal and illegal drugs, or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber’s direction, as well as those used illegally.

Name of Applicant: _____

“Currently” does not mean on the day of, or even in weeks or months preceding the completion of this application. Rather, it means recently enough so that the use of chemical substances or medical conditions may have an ongoing impact on the ability to function and practice, or has adversely affected the ability to function and practice within the past two (2) years.

“Improper use of drugs or other chemical substances” means ANY of the following:

1. The use of any controlled drug, legend drug, or other chemical substance for any purpose other than as directed by a licensed health care practitioner; and
2. The use of any substance, including but not limited to, petroleum products, adhesive products, nitrous oxide, and other chemical substances for mood enhancement.

“Illegal use of drugs or other chemical substances” means the manufacture, possession, distribution, or use of any drug or chemical substance prohibited by law.

PERSONAL & CONFIDENTIAL DATA

In answering each of the following questions, please check the appropriate box next to each question. **FOR EACH “YES” ANSWER TO QUESTIONS 1 THROUGH 22, YOU MUST PROVIDE A SIGNED STATEMENT GIVING FULL DETAILS, INCLUDING DATE(S), LOCATION(S), ACTION(S), ORGANIZATION(S) OR PARTIES INVOLVED, AND SPECIFIC REASON(S).**

Yes <input type="checkbox"/>	No <input type="checkbox"/>	1. Do you currently have a medical condition that in any way impairs or limits your ability to practice dentistry with reasonable skill and safety?
Yes <input type="checkbox"/>	No <input type="checkbox"/>	2. Are you currently engaged in the illegal or improper use of drugs or other chemical substances?
Yes <input type="checkbox"/>	No <input type="checkbox"/>	3. Do you currently use alcohol, drugs, or other chemical substances that would in any way impair or limit your ability to practice dentistry with reasonable skill and safety?
Yes <input type="checkbox"/>	No <input type="checkbox"/>	4. If YES to any of the above, are you receiving ongoing treatment or participating in a monitoring program that reduces or eliminates the limitations or impairments caused by either your medical condition or use of alcohol, drugs, or other chemical substances?
Yes <input type="checkbox"/>	No <input type="checkbox"/>	5. If YES to any of the above, does your field of practice, the setting, or the manner in which you have chosen to practice dentistry, reduce or eliminate the limitations or impairments caused by either your medical condition or use of alcohol, drugs, or other chemical substances?

If you answered yes to any of the questions above, please provide a signed statement below providing the details as requested in the instructions above. Please add a separate sheet of paper if necessary.

Signature

Date

Name of Applicant: _____

In answering each of the following questions, please check the appropriate box next to each question. **FOR EACH "YES" ANSWER TO QUESTIONS 1 THROUGH 22, YOU MUST PROVIDE A SIGNED STATEMENT GIVING FULL DETAILS, INCLUDING DATE(S), LOCATION(S), ACTION(S), ORGANIZATION(S) OR PARTIES INVOLVED, AND SPECIFIC REASON(S).**

Yes <input type="checkbox"/>	No <input type="checkbox"/>	6. Except for minor speeding or parking offenses, have you ever been arrested, charged, convicted, found guilty of, or entered a plea of guilty or no contest to a felony or misdemeanor crime or offense, including actions that resulted in a deferred or expunged judgment?
Yes <input type="checkbox"/>	No <input type="checkbox"/>	7. Have you ever been terminated or requested to withdraw from any dental school or training program?
Yes <input type="checkbox"/>	No <input type="checkbox"/>	8. Have you ever been requested to repeat a portion of any professional training program/school?
Yes <input type="checkbox"/>	No <input type="checkbox"/>	9. Have you ever received a warning, reprimand, or been placed on probation during a professional training program/school?
Yes <input type="checkbox"/>	No <input type="checkbox"/>	10. Have you ever been denied a license to practice dentistry?
Yes <input type="checkbox"/>	No <input type="checkbox"/>	11. Have you ever voluntarily surrendered a license issued to you by any professional licensing agency?
Yes <input type="checkbox"/>	No <input type="checkbox"/>	11a. If yes, was a license disciplinary action pending against you, or were you under investigation by a licensing agency at that time the voluntary surrender of license was tendered?
Yes <input type="checkbox"/>	No <input type="checkbox"/>	12. Have you ever been denied a Drug Enforcement Administration (DEA) or state controlled substance registration certificate?
Yes <input type="checkbox"/>	No <input type="checkbox"/>	13. Have you ever surrendered your state or federal controlled substance registration or had it restricted in any way?
Yes <input type="checkbox"/>	No <input type="checkbox"/>	14. Aside from ordinary initial requirements of proctorship, have your clinical activities ever been limited, suspended, revoked, not renewed, voluntarily relinquished, or subject to other disciplinary or probationary conditions?
Yes <input type="checkbox"/>	No <input type="checkbox"/>	15. Have you ever been terminated, sanctioned, penalized, had to repay monies to, or been denied provider participation in any state Medicaid, federal Medicare, or other publicly funded health care program?
Yes <input type="checkbox"/>	No <input type="checkbox"/>	16. Are any malpractice claims or complaints in process/pending against you?
Yes <input type="checkbox"/>	No <input type="checkbox"/>	17. Have any settlement agreements been rendered or any judgments entered against you resulting from your practice of dentistry?
Yes <input type="checkbox"/>	No <input type="checkbox"/>	18. Are charges or an investigation currently pending relative to your dental license in any other state?
Yes <input type="checkbox"/>	No <input type="checkbox"/>	19. Has any jurisdiction of the United States or other nation ever limited, restricted, warned, censured, placed on probation, suspended, or revoked a license you held?
Yes <input type="checkbox"/>	No <input type="checkbox"/>	20. Have you ever been notified of any charges filed against you by a licensing or disciplinary agency of any jurisdiction of the U.S. or other nation?

Name of Applicant: _____

In answering each of the following questions, please check the appropriate box next to each question. **FOR EACH "YES" ANSWER TO QUESTIONS 1 THROUGH 22, YOU MUST PROVIDE A SIGNED STATEMENT GIVING FULL DETAILS, INCLUDING DATE(S), LOCATION(S), ACTION(S), ORGANIZATION(S) OR PARTIES INVOLVED, AND SPECIFIC REASON(S).**

Yes <input type="checkbox"/>	No <input type="checkbox"/>	21. Do you have professional liability suits in process or pending?
Yes <input type="checkbox"/>	No <input type="checkbox"/>	22. Have any judgments or settlements been paid on your behalf as a result of a professional liability case(s)?
Yes <input type="checkbox"/>	No <input type="checkbox"/>	23. Do you understand that if a license is granted by this board, it will be based in part on the truth of the statements contained herein, which, if false, may subject you to criminal prosecution and revocation of the license?

AFFIDAVIT OF APPLICANT

I, _____, hereby declare under penalty of perjury that I am the person described and identified in this application. I also declare that I am the lawful holder of the enclosed diploma, which was procured in the regular course of instruction and examination without fraud or misrepresentation.

I further state that I have read the statutes and rules pertaining to the practice of dentistry as prescribed in Iowa Code chapters 147, 153, and 272C and 650 Iowa Administrative Code. If a license to practice dentistry is issued to me, I understand that if I violate any laws or rules, my license may be revoked as provided by law.

I declare, under penalty of perjury, that my answers and all statements made by me on this application and accompanying attachments are true and correct. Should I furnish any false information, or have substantial omission, I hereby agree that such act shall constitute cause for denial, suspension, or revocation of my license. I also declare under penalty of perjury that if I did not personally complete the foregoing application that I have fully read and confirmed each question and accompanying answer, and take full responsibility for all answers contained in this application.

I hereby agree to abide by the laws and rules pertaining to the practice of dentistry in the state of Iowa.

Signature of Applicant: _____ Date: _____

Name of Applicant: _____

APPLICATION ACKNOWLEDGEMENTS

FEES

Pursuant to Iowa Administrative Code 650—Chapter 15, application fees are non-refundable.

MODERATE SEDATION AND/OR GENERAL ANESTHESIA

Dentists licensed in the state of Iowa cannot administer deep sedation/general anesthesia or moderate sedation in the practice of dentistry unless a separate permit has been obtained from the Iowa Dental Board. Application for the general anesthesia or moderate sedation permits can be made by completing the online applications for General Anesthesia Permit or Moderate Sedation Permit, located in the 'Licensing' menu. For additional information, please refer to the Board's rules at Iowa Administrative Code 650-Chapter 29.

PUBLIC RECORDS

All or part of the information provided on the application form may be considered a public record under Iowa Code chapter 22 and Iowa Administrative Code 650-Chapter 6. Information on misconduct and examination results is not subject to disclosure. Criminal history may be subject to disclosure.

APPLICATIONS

Licenses are issued administratively following review of a completed application and all required credentials, unless the application warrants referral to the Licensure / Registration Committee, the full Board, or unless a personal appearance is required.

Applications are valid for only 180 days from the date of receipt. If the application has not been completed within 180 days, a new application and fee will have to be submitted if you wish to obtain a license in Iowa.

CPR ACKNOWLEDGEMENT

I hereby declare that I possess a valid certificate from a nationally-recognized course in CPR that includes a “hands-on” clinical component. I acknowledge that proof of certification will be maintained and made available to the Board upon request.

I hereby declare that I acknowledge the statements above concerning fees, moderate sedation and/or general anesthesia, public records, applications and CPR.

Signature: _____

Date: _____

AUTHORIZATION TO RELEASE INFORMATION

I, _____, do hereby authorize a disclosure of records concerning myself to the Iowa Dental Board (IDB). This release includes records of a public, private or confidential nature.

I acknowledge that the information released to the IDB may include material that is protected by federal and/or state laws applicable to substance abuse and mental health information. If applicable, I specifically authorize the release of confidential information to and from the IDB relating to substance abuse or dependence and/or mental health.

I further agree that the IDB may receive confidential information and records, including but not limited to the following records:

- Medical records
- Education records
- Personnel or employment records, including records of any remedial, probationary, disciplinary, or any other adverse information contained in those records.
- Residency or fellowship training records, including records of any remedial, probationary, disciplinary, or any other adverse information contained in those records.
- Any information the IDB deems reasonably necessary for the purposes set forth in this release.

Release of Liability. I do hereby irrevocably and unconditionally release, covenant not to sue, and forever discharge any person or entity, including but not limited to any dental school, residency or fellowship training program, hospital, health care provider, health care facility, licensing board, impaired practitioner program, agency, or organization, which releases information to the IDB pursuant to this release from any liability, claim, or cause of action arising out of the release of such information. I further irrevocably and unconditionally release, covenant not to sue, and forever discharge the IDB, the State of Iowa, and its employees and agents from any liability, claim, or cause of action arising out of the collection or release of information pursuant to this release.

A photocopy of this release form will be valid as an original thereof, even though the photocopy does not contain an original writing of my signature.

This authorization is effective through the completion of the licensure process. I understand I have the right to revoke this authorization in writing, except to the extent that the IDB has already taken action in reliance upon this consent.

I have read and fully understand the contents of this "Authorization to Release Information."

Signature of Applicant

Date

PROHIBITION ON REDISCLOSURE

This form does not authorize redisclosure of medical information beyond the limits of this consent. Where information has been disclosed from records protected by federal law for alcohol/drug abuse records or by state law for mental health records, federal requirements (42 C.F.R. Part 2) and state requirements (Iowa Code Ch. 228) prohibit further disclosure without the specific written consent of the patient except as provided in IAC 12.16(6)"b"2, or as otherwise permitted by such law and/or regulations. A general authorization for the release of medical or other information is not sufficient for these purposes. Civil and/or criminal penalties may attach for unauthorized disclosure of alcohol/drug abuse or mental health information.

CERTIFICATION OF EDUCATION

As part of the license application process, the Iowa Dental Board requires that the school at which the applicant received her/his dental or dental hygiene education complete this form. The completed form must be mailed directly from the school to the **IOWA DENTAL BOARD**. Any processing fees are the applicant's responsibility. The applicant's signature authorizes release of information, favorable or otherwise, directly to the board.

Print Name: _____

Date of Birth or Last 4 of SSN: _____

Signature: _____

Date: _____

This portion of the form should be completed by the school.

IT IS HEREBY CERTIFIED THAT _____
(Name of Applicant)

RECEIVED DENTAL EDUCATION AT _____
(Name of School)

LOCATED AT _____
(Full Address of School)

FROM _____ **TO** _____
(Month/Year) (Month/Year)

GRANTED A DIPLOMA WITH THE DEGREE OF _____

DATE DIPLOMA RECEIVED _____

Was the school accredited by the Commission on Dental Accreditation of the American Dental Association at the time the applicant graduated? **Yes** _____ **No** _____

Did the student ever receive a warning, reprimand? **Yes** _____ **No** _____

Was the student placed on probation or disciplined? **Yes** _____ **No** _____

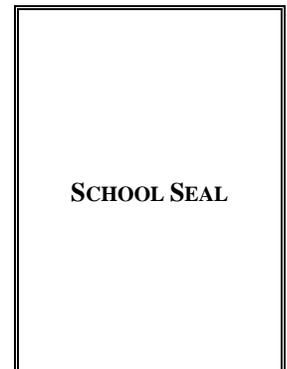
If yes, please provide details concerning the action taken.

President, Dean, Secretary, or Registrar:

Print Name _____ **Title** _____

Signature _____ **Date** _____

Phone # _____ **Fax #** _____



Return Completed Form to:
IOWA DENTAL BOARD
400 S.W. 8th St, Suite D
Des Moines, IA 50309-4687
Phone (515) 281-5157

CERTIFICATION OF LICENSURE

As part of the license application process, the Iowa Dental Board requires that this form be completed by every board that has ever issued any license to the applicant, even if the license is not current. The completed form must be mailed directly from the state licensing board to the **IOWA DENTAL BOARD**. Any processing fees are the applicant's responsibility. The applicant's signature authorizes release of information, favorable or otherwise, directly to the board.

Print Name: _____ **License #:** _____

Signature: _____ **Date:** _____

This portion of the form should be completed by the state licensing board.

IT IS HEREBY CERTIFIED THAT _____
(Name of Applicant)

WAS GRANTED LICENSE NUMBER _____ **DATE ISSUED** _____

TO PRACTICE _____ **IN THE STATE OF** _____

DATE OF EXPIRATION _____ **LICENSE STATUS** _____

BASIS FOR LICENSURE:

- NATIONAL BOARD EXAM
- LICENSURE BY CREDENTIALS
- STATE BOARD PREPARED WRITTEN AND/OR PRACTICAL EXAM
- REGIONAL CLINICAL EXAM, NAME OF TESTING AGENCY _____

SCORES ARE RECORDED AS FOLLOWS:

SUBJECT	PERCENT	SUBJECT	PERCENT
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

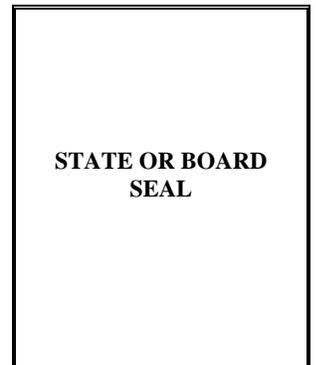
Scores are no longer available, however, I certify that it is apparent the applicant received a score sufficient to meet the licensure requirements of this state at that time; and these requirements were substantially equivalent to the requirements for licensure in Iowa.

YES NO **Disciplinary action ever been initiated, pending, or taken?**

Print Name _____ **Title** _____

Signature _____ **Date** _____

Phone # _____ **Fax #** _____



Return Completed Form to:
IOWA DENTAL BOARD
400 S.W. 8th St, Suite D
Des Moines, IA 50309-4687
Phone (515) 281-5157