

APPLICATION FOR IOWA DENTAL RESIDENT 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>

Please read the accompanying instructions prior to completing this application. Answer each question on the application. If not applicable, mark "n/a." Submit the non-refundable application fee of \$120, payable to the Iowa Dental Board, with this application.

1. IDENTIFYING INFORMATION

Full Legal Name: (Last, First, Middle, Suffix)			
Other Names Used: (e.g. Maiden)			
Home Address:			Telephone:
City:	County:	State:	Zip:
Work Address:			Telephone:
City:	County:	State:	Zip:
Home Fax:	Home E-mail:	Work Fax:	Work E-mail:
Social Security Number:		Privacy Act Notice: Disclosure of your Social Security Number on this license 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 licensees, and may also be shared with taxing authorities as allowed by law including Iowa Code § 421.18.	
Height:	Weight:	Hair Color:	Eye Color:
Identifying Marks:		U.S. Citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No	If No, Visa Type or Alien Registration Number:
Date of Birth:	City of Birth:	State of Birth:	Country of Birth:
Father's Full Name:		Mother's Full Name:	
Full Name & Address of Nearest Relative Not Living With You:			

2. PROGRAM FACILITY CERTIFICATION

Type of program/department affiliations:	Program begins:	Expected completion date:
Name of person responsible for supervision of applicant:		License/Permit Number:
I hereby agree to exercise supervision and direction over the applicant named above. Signature: _____		
I hereby certify that the above applicant is enrolled as a resident, intern, or graduate student dentist at this institution. Signature of Dean of the College of Dentistry or designated administrative officer: _____		

For Office Use Only	Resident License Number:	Diploma	Certification of Licensure:	Certification of Education:
	Date Issued:	Fee:	Marriage Certificate:	Photograph:

Name of Applicant _____

3. PRELIMINARY EDUCATION

Name of High School:	City, State:	From (Mo/Yr):	To (Mo/Yr):
Name of College:	City, State:	From (Mo/Yr):	To (Mo/Yr):
Name of College:	City, State:	From (Mo/Yr):	To (Mo/Yr):

4. DENTAL EDUCATION

Institution	City, State, Country	From (Mo/Yr):	To (Mo/Yr):
Year (1)			
Year (2)			
Year (3)			
Year (4)			
Degree Received:		Date of Degree:	

5. POST-GRADUATE DENTAL TRAINING

Institution:	Specialty:	From (Mo/Yr):	To (Mo/Yr):
Address:	City:	State/Province:	
Type of Training: <input type="checkbox"/> Intern <input type="checkbox"/> Resident <input type="checkbox"/> Fellow <input type="checkbox"/> Other (Be Specific) _____			

6. CHRONOLOGY OF ACTIVITIES

Provide a chronological listing of all dental and non-dental activities 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):

7. LICENSE INFORMATION

List all state/countries in which you are or have ever been licensed.				
State/Country	License No.	Date Issued	License Type (e.g. Resident, Faculty, Permanent)	How Obtained (e.g. Credentials, Exam)

DEFINITIONS FOR SECTION 8. 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.

“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.

SECTION 8. 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 SEPARATE, SIGNED STATEMENT GIVING FULL DETAILS, INCLUDING DATE(S), LOCATION(S), ACTION(S), ORGANIZATION(S) OR PARTIES INVOLVED, AND SPECIFIC REASON(S).**

- | YES | NO | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <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? |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Are you currently engaged in the illegal or improper use of drugs or other chemical substances? |
| <input type="checkbox"/> | <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? |
| <input type="checkbox"/> | <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? |
| <input type="checkbox"/> | <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? |
| <input type="checkbox"/> | <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? |
| <input type="checkbox"/> | <input type="checkbox"/> | 7. Have you ever been terminated or requested to withdraw from any dental school or training program? |
| <input type="checkbox"/> | <input type="checkbox"/> | 8. Have you ever been requested to repeat a portion of any professional training program/school? |
| <input type="checkbox"/> | <input type="checkbox"/> | 9. Have you ever received a warning, reprimand, or been placed on probation during a professional training program/school? |
| <input type="checkbox"/> | <input type="checkbox"/> | 10. Have you ever been denied a license to practice dentistry? |
| <input type="checkbox"/> | <input type="checkbox"/> | 11. Have you ever voluntarily surrendered a license issued to you by any professional licensing agency? |
| <input type="checkbox"/> | <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? |

Name of Applicant _____

YES NO

- 12. Have you ever been denied a Drug Enforcement Administration (DEA) or state controlled substance registration certificate?
- 13. Have you ever surrendered your state or federal controlled substance registration or had it restricted in any way?
- 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?
- 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?
- 16. Are any malpractice claims or complaints in process/pending against you?
- 17. Have any settlement agreements been rendered or any judgments entered against you resulting from your practice of dentistry?
- 18. Are charges or an investigation currently pending relative to your dental license in any other state?
- 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?
- 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?
- 21. Do you have professional liability suits in process or pending?
- 22. Have any judgments or settlements been paid on your behalf as a result of a professional liability case(s)?
- 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?

9. AFFIDAVIT OF APPLICANT

STATE OF _____ COUNTY OF _____

I, _____, hereby declare under penalty of perjury that I am the person described and identified in this application and that the attached photograph is a true likeness of myself. 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 resident license 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 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.

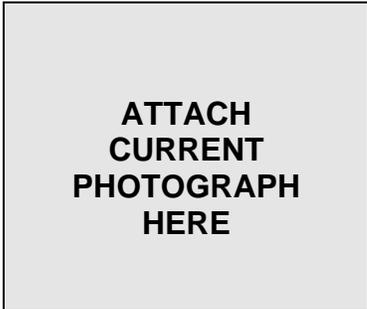
I hereby agree to abide by the laws and rules pertaining to the practice of dentistry in the state of Iowa.

Signature of Applicant _____

Sworn to before me this _____ day of _____, _____

My Commission Expires: _____

Signature of Notary Public _____



NOTARY SEAL

AUTHORIZATION TO RELEASE INFORMATION

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

I acknowledge that the information released to the Iowa Dental Board 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 Iowa Dental Board relating to substance abuse or dependence and/or mental health.

I further agree that the Iowa Dental Board 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 Iowa Dental Board 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 Iowa Dental Board 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 Iowa Dental Board, 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 Iowa Dental Board 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 Dentist

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 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 _____ **SS#** _____

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 _____
(Circle One) (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 _____
(Month/Year)

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

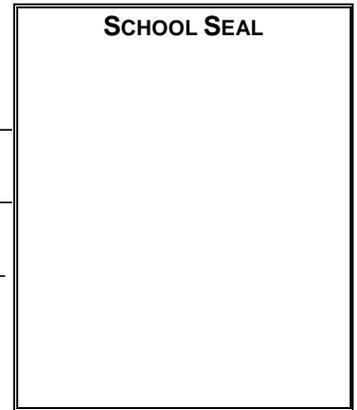
Did the student ever receive a warning, reprimand, or placed on probation or disciplined? Yes _____ No _____ If yes, please provide details concerning the action taken.

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 LICENSE EXPIRES _____ **LICENSE STATUS** _____

BASIS FOR LICENSURE:

- NATIONAL BOARD EXAM
- ENDORSEMENT/RECIPROCITY
- 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 #** _____

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