



# STATE OF IOWA

## IOWA DENTAL BOARD

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

JILL STUECKER  
EXECUTIVE DIRECTOR

### Iowa Retired Volunteer License Application

#### Eligibility

In order to be eligible for a retired volunteer license, one must comply with the following:

- Be retired from the practice of dentistry or dental hygiene; and
- Have held an *active* dental or dental hygiene license within the last 5 years; or satisfactorily demonstrate sufficient knowledge and skill to practice safely and competently if an active license has not been held within the 5 years immediately preceding the date of application.

**Retired volunteer licenses are valid for a period of 12 months following the date of issuance.**

#### Application Form

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

- For specific license requirements, please refer to the Board's rules at Iowa Administrative Code 650—Chapter 13.
- 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 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.**

#### Prohibitions

Practitioners who hold a retired volunteer license must adhere to the following restrictions:

- May not practice unless another Iowa licensed dentist with an active license is present at the location of practice at all times. (Screenings and educational programs may be performed without the presence of another licensee provided that compliance with all other Board rules are met in regards to supervision and permitted scope of practice.)
- Shall not charge a fee, receive compensation or remuneration in any form from any person or third-party payer.
- May not delegate services to other licensees or registrants.
- May not provide supervision to other licensees or registrants.
- May not prescribe, administer or dispense prescription drugs and all controlled substances.
- May not provide moderate sedation, deep sedation/general anesthesia, or local anesthesia.

**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 questions concerning these requirements, please notify the Board office.

**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.

**Contact Us**

If you have questions, or need further assistance, please contact the Board office at [IDB@iowa.gov](mailto:IDB@iowa.gov), or call 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](http://www.dentalboard.iowa.gov)

## Application Checklist

<input type="checkbox"/>	Application completely filled out; all questions answered.
<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"/>	For each "Yes" answer to questions 1 through 16, 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"/>	Evidence of having retired from practice.
<input type="checkbox"/>	Evidence of having held an active license within the last 5 years; <b>OR</b> satisfactory evidence of having sufficient knowledge and skill to practice safely and competently if it has been <i>more</i> than 5 years since an active license was held.



# APPLICATION FOR IOWA RETIRED VOLUNTEER LICENSE

## IOWA DENTAL BOARD

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

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

- Retired Volunteer Dental License**  
 **Retired Volunteer Dental Hygiene License**

This form must be completed and returned to the Iowa Dental Board. 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	<b>If no, visa type or alien registration number:</b> <input type="checkbox"/> Student Visa <input type="checkbox"/> Work Visa <input type="checkbox"/> Alien Registration <b>Provide visa or alien registration number:</b> <b>If visa, provide expiration date of current visa:</b>	
Social Security #:	<b>Privacy Act Notice:</b> 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:
<b>Are you currently serving in the military?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Are you a Veteran?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Are you the spouse of a Veteran?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Are you currently certified in CPR?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>CPR Expiration Date:</b>
<b>Name of Iowa dentist with an active license who will provide supervision, and license number:</b>				

<b>For office use only:</b>	<b>License #:</b>	<b>Date Issued:</b>	<b>Fees (App/Fprint):</b>
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Name of Applicant: \_\_\_\_\_

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

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**SPECIALTY INFORMATION**

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

**CHRONOLOGY OF ACTIVITIES**

Provide a brief chronological listing of all dental and dental hygiene activities for the last 5 years of practice. 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):

Name of Applicant: \_\_\_\_\_

### 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. 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.

**“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.



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 16, 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).**

<b>Yes</b> <input type="checkbox"/>	<b>No</b> <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?
<b>Yes</b> <input type="checkbox"/>	<b>No</b> <input type="checkbox"/>	7. Have you surrendered, resigned, converted, or allowed a license to lapse or expire as the result of or in lieu of disciplinary action? (If yes, you are ineligible to receive a retired volunteer license.)
<b>Yes</b> <input type="checkbox"/>	<b>No</b> <input type="checkbox"/>	8. Have you ever been denied a license to practice dentistry or dental hygiene?
<b>Yes</b> <input type="checkbox"/>	<b>No</b> <input type="checkbox"/>	9. Have you ever voluntarily surrendered a license issued to you by any professional licensing agency?
<b>Yes</b> <input type="checkbox"/>	<b>No</b> <input type="checkbox"/>	10. 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?
<b>Yes</b> <input type="checkbox"/>	<b>No</b> <input type="checkbox"/>	11. Are any malpractice claims or complaints in process/pending against you?
<b>Yes</b> <input type="checkbox"/>	<b>No</b> <input type="checkbox"/>	12. Have any settlement agreements been rendered or any judgments entered against you resulting from your practice of dentistry or dental hygiene?
<b>Yes</b> <input type="checkbox"/>	<b>No</b> <input type="checkbox"/>	13. Are charges or an investigation currently pending relative to your dental or dental hygiene license in any other state?
<b>Yes</b> <input type="checkbox"/>	<b>No</b> <input type="checkbox"/>	14. 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?
<b>Yes</b> <input type="checkbox"/>	<b>No</b> <input type="checkbox"/>	15. 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?
<b>Yes</b> <input type="checkbox"/>	<b>No</b> <input type="checkbox"/>	16. Do you have professional liability suits in process or pending?
<b>Yes</b> <input type="checkbox"/>	<b>No</b> <input type="checkbox"/>	<b>17. 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?</b>

Name of Applicant: \_\_\_\_\_

**AFFIDAVIT OF APPLICANT**

I, \_\_\_\_\_, hereby declare under penalty of perjury that I am the person described and identified in this application.

I further state that I have read the statutes and rules pertaining to the practice of dentistry or dental hygiene as prescribed in Iowa Code chapters 147, 153, and 272C and 650 Iowa Administrative Code. If a license to practice dentistry or dental hygiene 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 or dental hygiene in the state of Iowa.

Signature of Applicant: \_\_\_\_\_ Date: \_\_\_\_\_

**APPLICATION ACKNOWLEDGEMENTS**

**MODERATE SEDATION, GENERAL ANESTHESIA, LOCAL ANESTHESIA**

Dentists licensed in the state of Iowa cannot administer deep sedation/general anesthesia or moderate sedation in conjunction with a retired volunteer license.

Dental hygienists may not administer local anesthesia in conjunction with a retired volunteer license.

For additional information, please refer to the Board's rules at Iowa Administrative Code 650—Chapters 11, 13, and 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.

**REMUNERATION**

Practitioners who provide services under a retired volunteer license are prohibited from receiving payment or other compensation for the services provided.

**I hereby declare that I acknowledge the statements above concerning moderate sedation, general anesthesia, local anesthesia, public records, applications, and remuneration.**

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 or dental hygiene 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.