Maryland State Board of Dental Examiners

Spring Grove Hospital Center, Benjamin Rush Building

55 Wade Avenue/Tulip Drive • Catonsville, Maryland 21228 • (410) 402-8501

APPLICATION FOR DENTAL RADIATION TECHNOLOGIST CERTIFICATION BY WAIVER OF EXAMINATION CHECKLIST

Authority: Md. Code Ann., Health Occ. Article, § 4-505 and Code of Maryland Regulations (COMAR) 10.44.19.

INCLUDED	REQUIRED DOCUMENTS
☐	Completed **Notarized** Application (front and back)
☐	Initial Application Fee – $20.00 Check or Money Order payable to Maryland State Board of Dental Examiners **(NO CASH)**
☐	Passport size photograph with required notarized affidavit ***Please note guidelines include: 2x2 color photo with the head centered and sized between 1" and 1.4" taken in last 2 years, use a clear image of your face. Do not use filters commonly used on social media, have someone else take your photo. (No selfies) and use a plain white or off-white background. Unacceptable photos will be returned and may delay the issuance of your certificate.
☐	Certified letters with state seal affixed from each State you have ever held a certificate including verification of good standing.
☐	Notarized statement on previous employer's professional letterhead showing proof of active practice of at least 150 hours in the last 3years preceding the date of this application.
☐	A separate sheet of paper for Character and Fitness Questions that required a written explanation to questions answered "YES" (if applicable)
☐	Documentation of legal name change (i.e., marriage certificate, divorce decree, legal name change).

MAIL APPLICATION AND SUPPORTING DOCUMENTS TO:

Maryland State Board of Dental Examiners
Spring Grove Hospital Center, Benjamin Rush Building
55 Wade Avenue/Tulip Drive Catonsville, MD 21228

Maryland State Board of Dental Examiners

Spring Grove Hospital Center, Benjamin Rush Building

55 Wade Avenue/Tulip Drive • Catonsville, Maryland 21228 • (410) 402-8501

APPLICATION FOR DENTAL RADIATION TECHNOLOGIST CERTIFICATION BY WAVIER OF EXAMINATION

Authority: Md. Code Ann., Health Occ. Article, § 4-505 and Code of Maryland Regulations (COMAR) 10.44.19.

Please print clearly. The Dental Radiation Technologist initial certification fee is **$20.00** payable to **MARYLAND STATE BOARD OF DENTAL EXAMINERS.** Check and money orders accepted only. **NO CASH.**

NAME:

_____

First **Middle Initial** **Last**

STREET ADDRESS: _____

_____

TELEPHONE NUMBER:

HOME (____) _____ **WORK** (____) _____**CELL** (____) _____

EMAIL ADDRESS: _____

SOCIAL SECURITY NO: _____**BIRTHDATE:** _____

Gender Identification: _____Female _____Male _____Prefer not to answer

Race:
Are you of Hispanic or Latino Origin? **____ Yes ____ No _____ Prefer not to answer**

(**Please circle all applicable**; *for statistical purposes only*)
1 – White **2** – Black or African American **3** – American Indian or Alaska Native **4** – Asian **5** – Native Hawaiian or other Pacific Islander **6** – Other _____

Licensure in other states:
List other states or jurisdiction in which you hold a dental radiation technologist certification or license. Include certification/license number(s). **N/A** ☐

_____
STATE LICENSE/CERTIFICATE NO. EXPIRATION

_____
STATE LICENSE/CERTIFICATE NO. EXPIRATION

_____
STATE LICENSE/CERTIFICATE NO. EXPIRATION

CHARACTER AND FITNESS QUESTIONS

FOR THE FOLLOWING, CHECK **"YES"** OR "**NO"** IN THE BOX NEXT TO EACH QUESTION. IF YOU ANSWER **"YES"** TO ANY QUESTION(S), ATTACH A DETAILED EXPLANATION FOR EACH QUESTION ON A SEPARATE PAGE WITH COMPLETE EXPLANATION. ALL ATTACHMENTS MUST HAVE YOUR NAME IN PRINT, SIGNATURE, AND DATE.

YES NO

☐ ☐ **a)** Has any licensing or disciplinary board of any jurisdiction, **including** Maryland, or any federal entity denied your application for certification, reinstatement, or renewal, or taken any action against your license, including but not limited to reprimand, suspension, revocation, a fine, or non-judicial punishment? If you are under a Board Order or were ever under a Board Order in a state other than Maryland, you must enclose a certified legible copy of the entire Order with this application.

☐ ☐ **b)** Have any investigations or charges been brought against you or are any currently pending in any jurisdiction, **including** Maryland, by any licensing or disciplinary board or any federal or state entity?

☐ ☐ **c)** Has your application for a dental radiation technology certification in any jurisdiction been withdrawn for any reason?

☐ ☐ **d)** Has an investigation or charge been brought against you by a hospital, related institution, or alternative health care system?

☐ ☐ **e)** Have you had any denial of an application for privileges, been denied for failure to renew your privileges, or limitation, restriction, suspension, revocation, or loss of privileges in a hospital, related health care facility, or alternative health care system?

☐ ☐ **f)** Have you pled guilty, nolo contendere, had a conviction or receipt of probation before judgment or other diversionary disposition of any criminal act, excluding minor traffic violations?

☐ ☐ **g)** Have you pled guilty, nolo contendere, or receipt of probation before judgment or other diversionary disposition for an alcohol or controlled dangerous substance offense, including but not limited to driving while under the influence of alcohol or controlled substances?

☐ ☐ **h)** Do you have criminal charges pending against you in any court of law, excluding minor traffic violations?

☐ ☐ **i)** Do you have a physical condition that would impair your ability to practice dental radiation technology?

☐ ☐ **j)** Do you have a mental health condition that would impair your ability to practice dental radiation technology?

☐ ☐ **k)** Have the use of drugs and/or alcohol resulted in an impairment of your ability to practice dental radiation technology?

☐ ☐ **l)** Have you illegally used drugs?

☐ ☐ **m)** Have you surrendered or allowed a license to lapse while under investigation by any licensing or disciplinary board of any jurisdiction, **including** Maryland, or any federal, state entity?

☐ ☐ **n)** Have you been named as a defendant in a filing or settlement of a malpractice action?

☐ ☐ **o)** Has your employment been affected, or have you voluntarily resigned from any employment, in any setting, or have you been terminated or suspended, from any hospital, related health care or other institution, or any federal entity for any disciplinary reasons or while under investigation for disciplinary reasons?

REQUIREMENTS FOR CERTIFICATION

☐ Licensure or Certification: Attach documentation of an Active License or Certification to practice dental radiation in another State.

☐ Active Practice: Attach a Notarized Statement from one or more employers attesting that you have actively practiced dental radiation technology for at least 150 hours in the 3 years preceding the date of this application.

Note: Practice of Dental Radiation Technology in the Armed Forces, State, and Federal programs within the 3 years preceding your application counts toward the required hours of active practice.

☐ Passport size photograph with required notarized affidavit. Photo guidelines include: 2x2 color photo with the head centered and sized between 1" and 1.4" taken in last 2 years, use a clear image of your face. Do not use filters commonly used on social media, No telephone selfies. Use a plain white or off-white background. Unacceptable photos will be returned and may delay the issuance of your certificate.

Veterans, Service Members, and Military Spouses

If you are a veteran or service member you may meet the requirements for certification if you have completed a program in the military that included training and education in dental radiation technology of at least 24 hours. The Board will determine whether the military training and education is substantially equivalent to the Board-approved program. Veterans and service members, please attach either: 1) a copy of a certificate or record of training indicating that you have successfully completed a course that included at least 24 hours of training in dental radiation technology; or 2) a letter from either your commanding officer or the director of the training program indicating that you have successfully completed a course that included at least 24 hours of training in dental radiation technology. The original letter should be on letterhead and bear an original signature.

> "Veteran" is a former service member who was discharged from active duty under circumstances other than dishonorable within 1 (one) year before the date on which this application has been submitted. "Veteran" does not include an individual who has completed active duty and has been discharged for more than 1 year before the application for a license, certificate, or permit is submitted.
>
> "Service member" is an individual who is an active-duty member of the armed forces of the United States, a reserve component of the armed forces of the United States, or the National Guard of any state.
>
> "Military Spouse" is the spouse of a service member or veteran and includes the surviving spouse of a veteran or a service member who died within 1 (one) year before the date on which the application for licensure is submitted to the Board.

Veterans, service members and military spouses are assigned an advisor to assist in the application process. In addition, the Board will expedite the processing of completed applications for veterans, service members, and military spouses. If you do not meet the education or training or experience requirements for licensure, your advisor will assist you in identifying programs that offer relevant education or training, or ways to obtain the necessary experience.

Your advisor for this process is the Licensing Coordinator, who may be reached at 410-402-8501. Are you a:

Veteran ☐ Yes ☐ No **Service Member** ☐ Yes ☐ No **Military Spouse** ☐ Yes ☐ No

If you answered "Yes" to either "Veteran" or "Service Member" or "Military Spouse" and you did not complete a course that included at least 24 hours of training in dental radiation technology, you may provide a Notarized Statement from one or more commanding officers or employers attesting that you have actively practiced dental radiation technology for at least 150 hours in the 3 years preceding the date of this application..

RELEASE AND CERTIFICATION:

Practice of dental radiation technology without a current certification issued by the Maryland State Board of Dental Examiners is a violation of the Maryland Dentistry Act. I affirm that the contents of this document are true and correct to the best of my knowledge and belief. Failure to provide truthful answers may result in disciplinary action.

I agree that the Maryland State Board of Dental Examiners (the Board) may request any information necessary to process my application for dental radiation technologist certification in Maryland from any person or agency, including but not limited to postgraduate program directors, individual dentists, government agencies, the National Practitioner Data Bank, the Healthcare Integrity and Protection Data Bank, hospitals and other licensing bodies, and I agree that any person or agency may release to the Board the information requested. I also agree to sign any subsequent release for information that may be requested by the Board.

I agree that I will fully cooperate with any request for information or with any investigation related to my practice as a licensed dental radiation technologist in the State of Maryland, including the subpoena of documents or records.

During the period in which my application is being processed, I shall inform the Board within 30 days of any change to any answer I originally gave in this application, any arrest or conviction, any change of address or any action that occurs based on accusations that would be grounds for disciplinary action under the Code of Maryland Regulations (COMAR) 10.44.19.12.

Notice for Mailing List:

The information collected on this application form is collected for the purposes of the Board's functions under the Annotated Code of Maryland, Health Occupations Article, Title 4. Failure to provide the information may result in the denial of your application. You have a right to inspect, amend, and request correction of this information. The Board may permit inspection of this information or make it available to others only as permitted by federal and State law. Under the Maryland Public Information Act, Annotated Code of Maryland, General Provisions Article, §4-333, the Board may provide, for a fee, a list of licensees' names and addresses to professional associations and other entities. You may request in writing that your name be omitted from such lists.

_____ _____

Applicant Signature **Date**

NOTARY SECTION

State of _____, County of _____, then personally appeared the above named _____, and signed and sworn to the truth of the foregoing statements in my presence.

Notary Public: _____ My Commission Expires: _____

SEAL

Maryland State Board of Dental Examiners

Spring Grove Hospital Center, Benjamin Rush Building

55 Wade Avenue/Tulip Drive • Catonsville, Maryland 21228 • (410) 402-8501

PICTURE

*Please provide (1) 2x2 color photo with the head centered and sized between 1" and 1.4"

This is a true self photo taken in last 2 years to reflect my current appearance. In addition, the photograph is in accordance with the photograph requirements contained in an initial dental radiation technologist certificate application.

Print Name_____

Applicant Signature _____Date_____

NOTARY SECTION

State of _____, County of _____, then personally appeared the above named_____, and signed and sworn to the truth of the foregoing statements in my presence.

Notary Public: _____My Commission Expires:_____

SEAL

Revised 11/21/2022