**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 TO PARTICIPATE IN AN ADVANCED CLINICAL TRAINING PROGRAM FOR CONTINUING EDUCATION PURSUANT TO COMAR 10.44.22
## CHECKLIST

| INCLUDED | REQUIRED DOCUMENTS |
|---|---|
| ☐ | Completed **Notarized** Application (front and back) |
| ☐ | Certified Letter with the State Seal affixed from each state in which you hold a dental license, verifying that the license is in good standing. |
| ☐ | Passport size photograph with required notarized affidavit<br>***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. |
| ☐ | 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

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## TO BE COMPLETED ONLY BY THOSE DENTSITS WHO DO NOT HOLD A LICENSE TO PRACTICE DENTISTRY IN MARYLAND

**Notice**
This application is for dentists licensed in a state other than Maryland who wish to participate in an advanced clinical training program for continuing education within the State of Maryland. If you hold an active general license to practice dentistry in Maryland, you should not complete this application, and approval from the Maryland State Board of Dental Examiners ("the Board") is not required for you to attend an advanced clinical training program for continuing education. Dentists licensed in a state other than Maryland must receive written approval from the Board before they may participate in an advanced clinical training program for continuing education. ***Approval will allow you to participate and practice dentistry within the advanced clinical training program only.*** To ensure sufficient processing time, the completed application and $25 fee must be received in the offices of the Board at least 45 days before the commencement of the program. 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, and the Code of Maryland Regulations (COMAR) Title 10, Subtitle 44. Failure to provide the information may result in 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.

**SECTION I – GENERAL INFORMATION**

**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 jurisdictions in which you hold a dental license. Include license number(s). **Note: You must enclose with this application certified letters with the state seal affixed from each state in which you hold or held a dental license verifying that the license is or was in good standing**

______________________________________________________________________________

**STATE** **LICENSE NO.** **EXPIRATION DATE**

______________________________________________________________________________

**STATE** **LICENSE NO.** **EXPIRATION DATE**

______________________________________________________________________________

**STATE** **LICENSE NO.** **EXPIRATION DATE**

**SECTION II – ADVANCED CLINICAL TRAINING PROGRAM**

**A. Title of advanced clinical training program: ___________________________________________________**

**B. Full name of sponsor of advanced clinical training program: ______________________________________**

**B. Dates of program: ______________________________________________________________**

**C. Number of continuing education hours: __________________________________**

**D. Signature of Authorized Representative of Sponsor of advanced clinical training program. By signing the sponsor attests to the accuracy of the information contained in Section II:**

______________________________________________________________________________

**Signature** **Name printed** **Title**

**SECTION III - EDUCATION**

**A. School of graduation (Name, City, State, Country):**

______________________________________________________________________________

______________________________________________________________________________

**B. Date of graduation: _____________________ Degree earned: ______________________________**

## SECTION IV - CHARACTER AND FITNESS

**If you answer "YES" to any question(s) in Section IV – Character and Fitness, attach a separate page with a complete explanation of each occasion. Each attachment 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 licensure, 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 dentist license 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 application for privileges, been denied for failure to renew your privileges, or limitation, restriction, suspension, revocation or loss in 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, had a conviction, 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 dangerous 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 impairs your ability to practice dentistry? |
| ☐ | ☐ | **j)** Do you have a mental health condition that impairs your ability to practice dentistry? |
| ☐ | ☐ | **k)** Have the use of drugs and/or alcohol resulted in an impairment of your ability to practice dentistry? |
| ☐ | ☐ | **l)** Have you illegally used drugs? |
| ☐ | ☐ | **m)** Have you surrendered or allowed your license to lapse while under investigation by any licensing or disciplinary board of any jurisdiction, including Maryland, or any federal or 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? |

## SECTION V – MALPRACTICE INSURANCE

**A. Name of malpractice insurer:** ______________________________________________

**B. Name, address, and telephone number of malpractice insurance agent, or if no agent, the address and telephone number of the malpractice insurer:**

________________________________________________________________________

________________________________________________________________________

**C. Policy number:** ______________________________________________

**D. Amount of coverage:** ______________________________________________

**E. Expiration date of policy:** ______________________________________________

**RELEASE AND CERTIFICATION:**
I hereby affirm that I have read and followed the above instructions. I hereby certify that all information in this application is accurate and correct.

I agree that the Board may request any information necessary to process my application 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 dental practice as a licensed dentist including the subpoena of documents or records.

During the period in which my application is being processed, I shall inform the Board within forty-eight hours of any change to any answer I originally gave in this application, or change of address.

I agree that any approval I may receive from the Board to participate in a specific advanced clinical training program for continuing education shall be approval to participate in, and practice dentistry within that specific program only. Application must be made for, and approval obtained from the Board to participate in each advanced clinical training program for continuing education.

**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**