

**Maryland State Board of Dental Examiners**  
**Spring Grove Hospital Center, Benjamin Rush Building**  
**55 Wade Avenue/Tulip Drive • Catonsville, Maryland 21228 • (410) 402-8500**

**APPLICATION FOR RECOGNITION OF OUT-OF-STATE DENTAL LICENSURE PURSUANT TO THE VETERANS  
 AUTO AND EDUCATION IMPROVEMENT ACT OF 2022 (50 U.S.C.A. § 4025a) CHECKLIST**

INCLUDED	REQUIRED DOCUMENTS
<input type="checkbox"/>	Completed <b>Notarized</b> Application (front and back)
<input type="checkbox"/>	Copy of military orders indicating military service in a state other than any state in which you hold a dental license (or if application is for a spouse, provide the sponsor’s military orders indicating the spouse’s name, or in cases where military orders do not have the spouse’s name listed, provide a copy of the marriage certificate with the military orders).
<input type="checkbox"/>	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.
<input type="checkbox"/>	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.
<input type="checkbox"/>	A separate sheet of paper for Character and Fitness Questions that required a written explanation to questions answered “YES” (if applicable)
<input type="checkbox"/>	Documentation of legal name change (i.e., marriage certificate, divorce decree, legal name change).

**MAIL APPLICATION AND SUPPORTING DOCUMENTS TO:**  
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AUTO AND EDUCATION IMPROVEMENT ACT OF 2022 (50 U.S.C.A. § 4025a)**

**COMPLETE THIS APPLICATION ONLY IF:**

- (1) YOU ARE A DENTIST WHO IS PRESENTLY A SERVICEMEMBER OR A DENTIST WHO HAS A SPOUSE WHO IS A SERVICEMEMBER;
- (2) YOU HAVE A DENTAL LICENSE IN A STATE OR STATES OTHER THAN MARYLAND THAT ARE IN GOOD STANDING AND THAT YOU HAVE ACTIVELY USED DURING THE 2 YEARS IMMEDIATELY PRECEDING YOUR RESIDENCY IN MARYLAND;.
- (3) EITHER YOU OR YOUR SPOUSE ARE UNDER ORDERS TO PROVIDE MILITARY SERVICE OUTSIDE OF THE STATE OR STATES IN WHICH YOU HOLD A DENTAL LICENSE;
- (4) YOU RESIDE IN MARYLAND; AND
- (5) YOU OR YOUR SPOUSE SEEK RECOGNITION TO PRACTICE DENTISTRY IN MARYLAND THAT IS EFFECTIVE ONLY DURING (a) THE PENDENCY OF YOUR OR YOUR SPOUSE’S MILITARY SERVICE OUTSIDE OF THE STATES IN WHICH YOU HOLD A DENTAL LICENSE; AND (b) DURING THE PERIOD IN WHICH YOU RESIDE IN MARYLAND.

THERE IS NO FEE ASSOCIATED WITH THIS APPLICATION.

**IF YOU SEEK A GENERAL MARYLAND DENTAL LICENSE THAT DOES NOT EXPIRE WHEN EITHER YOUR OR YOUR SPOUSE’S MILITARY ORDERS EXPIRE OUTSIDE OF THE STATES IN WHICH YOU HOLD A DENTAL LICENSE, OR WHEN YOU CEASE TO RESIDE IN MARYLAND, DO NOT COMPLETE THIS APPLICATION. INSTEAD, COMPLETE THE APPLICATION FOR DENTAL LICENSURE BY EXAMINATION OR DENTAL LICENSURE BY WAIVER OF PRACTICAL CLINICAL EXAMINATION, WHICHEVER IS APPROPRIATE. THERE IS A FEE ASSOCIATED WITH THOSE APPLICATIONS.**

**Please note the following:**

*"Servicemember"* is defined as a member of the "uniformed services." "Uniformed services" means (a) the armed forces; (b) the commissioned corps of the National Oceanic and Atmospheric Administration; and (c) the commissioned corps of the Public Health Service. "Armed forces" is defined as "Army, Navy, Air Force, Marine Corps, Space Force, and Coast Guard."

*"Spouse"* is defined as "husband or wife, as the case may be."

*"Reside in the State of Maryland"* is defined as Maryland being the site of your primary residency.

**Are you a:**

**Servicemember:**  Yes  No      **Spouse of a Servicemember:**  Yes  No

**SECTION I- INITIAL QUALIFICATIONS for SERVICEMEMBER (Servicemember spouses will answer in the next section)**

You must meet the following initial qualifications to obtain a Servicemember Dental Recognition. If you answer "No" to any of the questions in SECTION I – Initial Qualifications for SERVICEMEMBER you may not be considered for a Servicemember Dental Recognition. Other requirements also apply.

**Servicemembers only please answer the following questions.**

- |                          |                          |  |
|--------------------------|--------------------------|--|
| <b>YES</b>               | <b>NO</b>                |  |
| <input type="checkbox"/> | <input type="checkbox"/> | a. Are you presently a "servicemember" as defined on page 1?                                       |
| <b>YES</b>               | <b>NO</b>                |  |
| <input type="checkbox"/> | <input type="checkbox"/> | b. Do you "reside" (as that word is defined on page 1) in Maryland as a result of military orders? |
| <b>YES</b>               | <b>NO</b>                |  |
| <input type="checkbox"/> | <input type="checkbox"/> | c. Are all dental licenses that you presently hold in other states in "good standing"?             |

YES NO

d. Have you actively used one or more dental licenses during the two years immediately preceding your relocation to Maryland?

YES NO

e. Are you recognized as a dental specialist in any state?

**SECTION II- INITIAL QUALIFICATIONS for SERVICEMEMBER SPOUSE**

You must meet the following initial qualifications to obtain a Servicemember Spouse Dental Recognition. If you answer "No" to any of the questions in SECTION II- Initial Qualifications FOR SERVICEMEMBER SPOUSE you may not be considered for a Servicemember Spouse Dental Recognition. Other requirements also apply.

**Servicemembers spouses only please answer the following questions.**

YES NO

a. Are you presently the spouse of a "servicemember" as those terms are defined on page 1?

YES NO

b. Do you or your spouse "reside" (as that word is defined on page 1) in Maryland as a result of your spouse's military orders?

YES NO

c. Are all dental licenses that you presently hold in other states in "good standing"?

YES NO

d. Have you actively used one or more dental licenses during the two years immediately preceding your relocation to Maryland?

YES NO

e. Are you recognized as a dental specialist in any other state?

**SECTION III – GENERAL INFORMATION**

**NAME:**

\_\_\_\_\_

<b>First</b>	<b>Middle Initial</b>	<b>Last</b>
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**PRIMARY RESIDENCE STREET ADDRESS:**

\_\_\_\_\_  
\_\_\_\_\_

**TELEPHONE NUMBER:**

HOME (\_\_\_\_) \_\_\_\_\_ WORK (\_\_\_\_) \_\_\_\_\_ CELL (\_\_\_\_) \_\_\_\_\_

**EMAIL ADDRESS:** \_\_\_\_\_

**SOCIAL SECURITY NO:** \_\_\_\_\_ **BIRTHDATE:** \_\_\_\_\_

**Gender Identification:** \_\_\_\_\_ Female \_\_\_\_\_ Male \_\_\_\_\_ Other \_\_\_\_\_ 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).

STATE	LICENSE NO.	EXPIRATION
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**Specialty:**

If you are recognized as a dental specialist in other state(s) provide the following information:

STATE	Specialty	Identification No. if applicable
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**SECTION IV - CHARACTER AND FITNESS – TO BE ANSWERED BY SERVICEMEMBERS AND THEIR SPOUSES**

**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) Are you presently under a board order in a state other than Maryland? If so, you must enclose a certified legible copy of the entire Order with this application.
- b) Are there any investigations or charges currently pending in any jurisdiction, including Maryland, by any licensing or disciplinary board or any federal or state entity?
- c) 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?
- d) Do you have criminal charges pending against you in any court of law, excluding minor traffic violations?
- e) Do you have a physical condition that would impair your ability to practice dentistry?
- f) Do you have a mental health condition that would impair your ability to practice dentistry?
- g) Have the use of drugs and/or alcohol resulted in an impairment of your ability to practice dentistry?
- h) Have you illegally used drugs?
- i) Have you been named as a defendant in a filing or settlement of a malpractice action?
- j) 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?

**RELEASE AND CERTIFICATION:**

**Practice of dentistry without a current recognition of out-of-state dental licensure 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 Recognition of Out-of-State Dental Licensure Pursuant to the Veterans Auto and Education Improvement Act of 2022 (50 U.S.C.A. § 4025a) 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 dentist 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 Annotated Code of Maryland, Health Occupations Article, § 4-315.

**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**

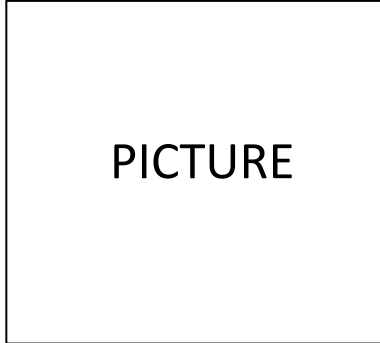
**NOTARY SECTION**

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**

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\*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 8/15/2023