Maryland State Board of Dental Examiners
Spring Grove Hospital Center • Benjamin Rush Building
55 Wade Avenue/Tulip Drive
Catonsville, Maryland 21228
(410) 402-8511

APPLICATION FOR TEMPORARY VOLUNTEER DENTIST'S LICENSE

Note: In order to initially qualify for a temporary volunteer dentist's license, you must currently hold an active general license to practice dentistry in a state other than Maryland that permits clinical practice and is not subject to clinical restrictions. In addition, you must have **either**: 1) Passed the North East Regional Board Clinical Examination, **or** 2) Have, for at least 5 years preceding your application, held a general license to practice dentistry in another state that permits clinical practice, and, in that 5 year period you must have actively engaged in practicing dentistry for at least 850 hours on average per year. (A total of at least 4,250 hours). Those who do not meet these initial requirements may not be considered for a temporary volunteer dentist's license. In addition, either you or the entity that is hosting the temporary dental clinic must provide evidence to the Board that you are covered by malpractice insurance for the duration of the temporary dental clinic.

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 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.

SECTION I – GENERAL INFORMATION

Name (Last, First, Middle Initial):	
Address of Record: (Street Address)	
City, State, Zip:	

A. Social Security Number: ☐☐☐-☐☐-☐☐☐☐
(There is a statutory requirement that you disclose your social security number. It will be used for identification purposes only.)

B. Date of Birth: ☐☐-☐☐-☐☐☐☐

C. Cell Phone Number: ☐☐☐-☐☐☐-☐☐☐☐

D. Home Phone Number: ☐☐☐-☐☐☐-☐☐☐☐

E. Work Phone Number: ☐☐☐-☐☐☐-☐☐☐

F. E-Mail Address: ☐

G. Gender Identification: ☐ Female ☐ Male

H. Race/Ethnic Identification – Please check <u>all</u> that apply

Are you of Hispanic or Latino origin? Yes ☐ No ☐ (A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.)

Select one or more of the following racial categories:

1. ☐ American Indian or Alaska Native (A person having origins in any of the original peoples of North or South America, including Central America, and who maintains tribal affiliations or community attachment.)
2. ☐ Asian (A person having origin in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.)
3. ☐ Black or African American (A person having origins in any of the black racial groups of Africa.)
4. ☐ Native Hawaiian or other Pacific Islander (A person having origins in the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.)
5. ☐ White (A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.)

<u>SECTION II – Temporary Dental Clinic</u>

A. Name and address of Temporary Dental Clinic for which you seek a temporary volunteer dentist's license.

_____

_____

_____

B. Name, address, and telephone number of temporary dental clinic coordinator.

_____

_____

_____

C. Is the temporary dental clinic operated by a:

- ☐ Bona fide charitable organization; or
- ☐ The State or Local Government; or
- ☐ A Local Health Department

D. Dates the temporary dental clinic will be held.

_____

E. Location of temporary dental clinic.

_____

_____

_____

_____

SECTION III - EDUCATION

A. School of Graduation (Name, City, State, Country): _____

_____

B. Date of Graduation: _____ **Degree Earned:** _____

Note: In order to initially qualify for a temporary volunteer dentist's license, you must meet the requirements of either Section IV or Section V.

SECTION IV – AMERICAN BOARD OF DENTAL EXAMINERS (ADEX) OR THE NORTH EAST REGIONAL BOARD (NERB) CLINICAL EXAMINATION

A. Have you passed the **American Board of Dental Examiners (ADEX) or the North East Regional Board (NERB) Clinical Examination**? ☐ Yes ☐ No

B. Date of examination: _____ Location of examination: _____

SECTION V – EXPERIENCE

A. ☐ Yes ☐ No For at least 5 years preceding my application I have held a general license to practice dentistry that permits clinical practice, and in that 5 year period I have been actively engaged in practicing dentistry for at least 850 hours on average per year for a cumulative total of at least 4,250 hours. In addition, the license is not subject to clinical restrictions.

SECTION VI – Licensure in Other States

A. List other states or jurisdictions in which you hold or have held a general license to practice dentistry that permits clinical practice. Include license number(s).

State	License Number

B. For the 5-year period preceding the date of your application:

1) Identify the state(s) in which held a dental license; 2) The date(s) you actively practiced dentistry in each of those state(s); and 3) The number of hours you practiced in each of those state(s).

State Dates of Active Practice Number of Hours of Practice

_____

_____

_____

_____

C. Do you hold a general license to practice dentistry in any state or jurisdiction that is currently subject to clinical restrictions? ☐ Yes ☐ No If you answered "Yes" please attach a separate page with a complete explanation including a certified copy of the order and the date on which the restriction is scheduled to be lifted.

SECTION VII – Cardiopulmonary Resuscitation Certification (CPR)

☐ Yes ☐ No I have attached current verification of CPR certification. **(Required)**

SECTION VIII – Malpractice Insurance

☐ Yes ☐ No Do you carry a policy of malpractice insurance that will cover you for the duration of the temporary dental clinic. If you answered "Yes" please complete the Malpractice Insurance Affidavit below. If you do not, the entity hosting the temporary dental clinic must provide evidence to the Board that you are covered by malpractice insurance for the duration of the event. Please check with the entity hosting the event.

SECTION IX- CHARACTER AND FITNESS

If you answer "YES" to any question(s) in this section, 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 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 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 ay 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?

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 Maryland State Board of Dental Examiners (the Board) may request any information necessary to process my application for a temporary volunteer dentist's license 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 this application or to my practice as a temporary volunteer dentist, including the subpoenaing of documents or records or the inspection of my dental practice.

During the period in which my application is being processed I shall inform the Board 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.

_____ _____

Applicant Signature **Date**

COMPLETE EITHER THE ADEX/NERB AFFIDAVIT OR THE EXPERIENCE AFFIDAVIT

EXPERIENCE AFFIDAVIT

5 YEARS AND 4250 HOURS EXPERIENCE REQUIREMENT

For at least 5 years preceding my application I have held a general license to practice dentistry that permits clinical practice that is not subject to clinical restrictions, and in that 5 year period I have been actively engaged in practicing dentistry for at least 850 hours on average per year for a cumulative total of at least 4,250 hours.

_____ _____

Signature of Applicant **Date**

ADEX/NERB AFFIDAVIT

I have passed the American Board of Dental Examiners (ADEX) or the North East Regional Board (NERB) Clinical Examination.

_____ _____

Signature of Applicant **Date**

DONATION OF DENTAL SERVICES AFFIDAVIT
(Required)

I hereby agree that if I am granted a temporary volunteer dentist's license that I will donate dental services for the temporary dental clinic that I have identified in this application without compensation; and further, I agree that I do not practice dentistry in Maryland for profit.

_____ _____

Signature of Applicant **Date**

MALPRACTICE INSURANCE AFFIDAVIT

(Required if the entity hosting the temporary dental clinic has not provided malpractice insurance for you for the duration of the temporary dental clinic)

A. Name of Malpractice Insurer:

_____
_____
_____

B. Name, Address, and telephone number of Malpractice Insurance Agent:

_____
_____
_____
_____
_____
_____
_____

C. If You Do Not Have an Agent, Provide the Address and Telephone Number of the Malpractice Insurer:

_____
_____
_____
_____

D. Policy Number _____

E. Amount of Coverage _____

F. Expiration Date of Policy _____

_____ _____

Signature of Applicant **Date**

NOTARY

STATE OF _____, CITY/COUNTY OF_____

I HEREBY CERTIFY THAT on this _____ day of _____, 20_, before me, a Notary Public of the State of _____ and the City/County aforesaid, personally appeared before me _____, and made oath in due form of law that the information contained in the Release and Certification three foregoing Affidavits are true and correct to the best of his\her knowledge and belief.

AS WITNESS my hand and Notarial Seal.

_____

Notary Public

My Commission Expires: _____

MAIL APPLICATION AND SUPPORTING DOCUMENTS TO:

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

Revised 11-07-19

Application for Temporary Volunteer Dentist's License

Checklist

Please review prior to sending your application package to the Board.

☐ 1. Is your application completed front and back?

☐ 2. Did you sign and have the application notarized?

☐ 3. Did you enclose a certified letter with the state seal affixed from each state in which you hold a general license to practice dentistry, verifying that you: 1) presently hold a general license to practice dentistry that permits clinical practice in that state; and 2) that the license is not subject to clinical restrictions.

☐ 4. Did you enclose the ADEX/NERB Affidavit; or

☐ 5. The Experience Affidavit?

☐ 6. Did you enclose the completed Donation of Dental Services Affidavit? **(Required)**

☐ 7. Did you enclose the completed Malpractice Insurance Affidavit? (Required if the entity hosting the temporary dental clinic has not provided malpractice insurance for you for the duration of the temporary dental clinic.)

☐ 8. Did you enclose proof of current cardiopulmonary resuscitation (CPR) certification? **(Required)**

☐ 9. Did you enclose documentation of legal name change (i.e., marriage certificate or court documents)) if the documents sent with the application are in another name?