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 DENTAL ASSISTANT QUALIFIED IN GENERAL DUTIES

Authority: Md. Code Ann., Health Occ. Article, § 4-205, Annotated Code of Maryland

The Board **may not** process a certification application until each provision or requirement is met and each document is received. Please ensure that your application is complete before it is submitted.

Application For Dental Assistant Qualified in General Duties

An individual may apply for registration if the applicant:

1) Completes a dental assistant qualified in general duties application; and
2) Passport size photograph with required notarized affidavit
3) Provides proof of completion of 35 hours of Board approved course in dental assisting general duties
4) Provides completed Dental Assistant National Board (DANB) Maryland Dental General (MDG) or General Chairside (GC) Examination - **official passing letter results**
5) A separate sheet of paper for Character and Fitness Questions that required a written **signed and dated** explanation to questions answered "YES" (if applicable)
6) Pays to the Board a certification fee of $20 – must be a check or money order made payable to the Maryland State Board of Dental Examiners **(NO CASH)**
7) Documentation of legal name change (i.e., marriage certificate, divorce decree, legal name change – if applicable).
8) If you relocate during the time that your application is being processed, you must notify the Board of your new address in writing by fax 410-402-8505 or email to mdh.md.dentalboard@maryland.gov. This will enable you to receive Board correspondence. Should you relocate after receiving your certificate, you must notify the Board within 60 days. A fine of $10 will be assessed after 60 days.

MAIL APPLICATION AND SUPPORTING DOCUMENTS TO:

Maryland State Board of Dental Examiners
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Please print clearly. The Dental Assistant Qualified in General Duties initial certification fee is **$20.00** payable to **MARYLAND STATE BOARD OF DENTAL EXAMINERS.** Check and money orders accepted only. **NO CASH.**

Information for Veterans, Service Members, and Military Spouses

Please note the following:

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 assisting general duties of at least 35 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 35 hours of training in dental assisting general duties; 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 35 hours of training in dental assisting general duties. 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.

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

If you answered "Yes" to either "veteran" or "service member" and you wish to utilize military education or training in dental assisting general duties that is substantially equivalent to the required 35-hour Board-approved course, you must attach documentation to this application that provides sufficient proof that you are a veteran or service member. If you are a service member, please attach a copy of a statement of service signed by your commanding officer. If you are a veteran, please attach a copy of your DD-214 form.

SECTION I – NAME AND ADDRESS (must be completed)

Law requires certificate holders to notify the Board of a name or address change within 60 days. If your name has changed, please submit proof of legal name change (marriage certificate, divorce decree, or other court document certifying a legal name change).

NAME: _____

Last First Middle Initial

Non-Public Address: The non-public (home) address will be the location to which the Board directs all correspondence. This address is confidential. Do not use your practice address. (Do not use a P.O. Box). If you change your address immediately notify the Board in writing.

_____

_____

Public Address: The public address (business) address is your address of record, available to the public, and may be posted on the Board's website.

_____

_____

SECTION II – GENERAL INFORMATION (must be completed)

Non-Public Telephone Number: The non-public telephone number is typically your home or cell number. It is confidential.

_____

Public Telephone Number: Your public telephone number (business) will be available to the public. and may be posted on the Board's website.

_____

Non-Public Email Address: The non-public e-mail address may be used by the Board and is confidential.

_____

Public Email Address: The public e-mail address (business) is your address of record, available to the public, and may be posted on the Board's website.

_____

SOCIAL SECURITY NUMBER or INDIVIDUAL TAX IDENTIFICATION NUMBER:

_____

There is a statutory requirement that you disclose your social security number. It will be used for identification purposes only. If you do not have a social security number or a tax identification number, please contact the Board for further instructions.

BIRTHDATE: _____

GENDER IDENTIFICATION: _____FEMALE _____MALE _____PREFER NOT TO ANSWER

RACE (**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 _____ **7** – Prefer Not To Answer

Are you of Hispanic or Latino Origin? **____ YES ____ NO _____ PREFER NOT TO ANSWER**

LICENSURE IN OTHER STATES:
List other states or jurisdiction in which you hold a dental certification or license. Include certification/license number(s). **N/A ☐**

STATE	LICENSE/CERTIFICATE NO.	ISSUED DATE	EXPIRATION DATE
STATE	LICENSE/CERTIFICATE NO.	ISSUED DATE	EXPIRATION DATE
STATE	LICENSE/CERTIFICATE NO.	ISSUED DATE	EXPIRATION DATE

SECTION III - EXAMINATION

A. Have you completed the Dental Assistant National Board (DANB) Maryland Dental General (MDG) or General Chairside (GC) Examination?
YES _____ NO _____

B. Date of Examination _____ Location of Examination _____

SECTION IV - CHARACTER AND FITNESS

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 assistant qualified in general duties 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?

SECTION IV - CHARACTER AND FITNESS CONT'D

☐ ☐ **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 assisting qualified in general duties?

☐ ☐ **j)** Do you have a mental health condition that would impair your ability to practice dental assisting qualified in general duties?

☐ ☐ **k)** Have the use of drugs and/or alcohol resulted in an impairment of your ability to practice dental assisting qualified in general duties?

☐ ☐ **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 court of law in a malpractice action **or** have you, either personally or through an insurance carrier, settled a malpractice claim, regardless of whether that claim was settled in a court of law?

☐ ☐ **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?

The Well Being Committee assists dental assistants and their families who are experiencing personal problems. The Committee has helped a number of dental assistants over the years with problems such as stress, drug dependence, alcoholism, depression, medical problems, infectious diseases, neurological disorders and other illnesses that cause impairment. For more information, please call 1-800-974-0068 or visit the website at www.mdhawell-being.org.

Release and Certification:
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 registration 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 Dental Assistant Qualified in General Duties 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 §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 MD, 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, the Annotated Code of MD, General Provisions Article, §4-101 et seq., 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**

Revised: 08/05/2025

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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

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QUALIFIED IN GENERAL DUTIES CHECKLIST

Authority: Md. Code Ann., Health Occ. Article, § 4-205, Annotated Code of Maryland

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.
☐	Completed 35 hours of Board approved course in dental assisting general duties (classroom only)
☐	Completed Dental Assistant National Board (DANB) Maryland Dental General (MDG) or General Chairside (GC) Examination - **official passing letter results**
☐	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 – if applicable).
☐	If you relocate during the time that your application is being processed, you must notify the Board of your new address in writing by fax 410-402-8505 or email to mdh.md.dentalboard@maryland.gov. This will enable you to receive Board correspondence. Should you relocate after receiving your license, you must notify the Board within 60 days. A fine of $10 will be assessed after 60 days.

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