

**Maryland State Board of Dental Examiners  
Spring Grove Hospital Center • Benjamin Rush Building  
55 Wade Avenue/Tulip Drive  
Catonsville, Maryland 21228  
(410) 402-8509**

**APPLICATION FOR REINSTATEMENT OF  
DENTAL RADIATION TECHNOLOGIST CERTIFICATE**

**Notice for Mailing List:**

The information collected on this application form is collected for the purposes of the Board's functions under Annotated Code of Maryland, Health Occupations, 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.

Your application must be fully completed and signed, in order to be processed. Incomplete forms will be returned and will cause your reinstatement to be delayed. **Practicing without a current active certification issued by this Board is a violation of the Maryland Dentistry Act and could result in disciplinary action, including suspension and revocation.**

Your advisor is Debbie Wurster. Ms. Wurster may be reached at 410-402-8509. In Ms. Wurster's absence, you may contact Ms. Debbie Welch at 410-402-8511.

Address: The Board must, by law, have a valid address for you. The address you provide is the "address of record" that is available for public information requests and the address to which the Board will forward all correspondence. The Board does not send certifications to post office boxes. You must provide a street address. Please provide a telephone number where you can be reached during the day in the event the Board needs to contact you regarding the processing of your application.

**SECTION I – NAME AND ADDRESS**

Law requires certificate holders to notify the Board of a name or address change within 60 days.

<b>Name (Last, First, Middle Initial):</b>	
<b>Street Address:</b>	
<b>City, State, Zip:</b>	

**REINSTATEMENT FEES – PAYABLE TO MARYLAND STATE BOARD OF DENTAL EXAMINERS**

Dental Radiation Technologist - \$118.00

**SECTION II – GENERAL INFORMATION**

**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. Home Phone Number:**           -    -

**D. Work Phone Number:**           -    -

**E. E-Mail Address:**               

**F. Gender:**         Female     Male

**G. Race/Ethnic Identification – Please check all that apply**

Are you of Hispanic or Latino origin?    Yes <input type="checkbox"/> No <input type="checkbox"/> (A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.)
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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.)

**H. 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).

State	Certification/License Number

**SECTION III - CHARACTER AND FITNESS**

**If you answer "YES" to any question(s) in Section III – 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**

- |                          |                          |   |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | 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. |
| <input type="checkbox"/> | <input type="checkbox"/> | 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?   |
| <input type="checkbox"/> | <input type="checkbox"/> | c. Has your application for a dental radiation technology certification in any jurisdiction been withdrawn for any reason?  |
| <input type="checkbox"/> | <input type="checkbox"/> | d. Has an investigation or charge been brought against you by a hospital, related institution, or alternative health care system?   |
| <input type="checkbox"/> | <input type="checkbox"/> | e. Have you had any denial of application for privileges, 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?  |
| <input type="checkbox"/> | <input type="checkbox"/> | 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?   |
| <input type="checkbox"/> | <input type="checkbox"/> | 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?   |
| <input type="checkbox"/> | <input type="checkbox"/> | h. Do you have criminal charges pending against you in any court of law, excluding minor traffic violations?  |
| <input type="checkbox"/> | <input type="checkbox"/> | i. Do you have a physical condition that impairs your ability to practice dental radiation technology?  |
| <input type="checkbox"/> | <input type="checkbox"/> | j. Do you have a mental health condition that impairs your ability to practice dental radiation technology?   |
| <input type="checkbox"/> | <input type="checkbox"/> | k. Have the use of drugs and/or alcohol resulted in an impairment of your ability to practice dental radiation technology?  |
| <input type="checkbox"/> | <input type="checkbox"/> | 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?

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.mdhawaii-being.org](http://www.mdhawaii-being.org).

**SECTION IV – REQUIREMENTS FOR REINSTATEMENT**

- a. Dental Continuing Education. Attach proof of completion of 8 classroom hours of dental continuing education, 4 hours of which are on the subject radiation safety, taken within the one-year preceding application for reinstatement. In addition, I have attached completion of a 2-hour Board-approved course on infection control.
- b. Enclose a notarized statement, indicating whether you have practiced dental radiation technology, which is the placement or exposure of dental radiographs. If yes, please include the month, day and year.

**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.

\_\_\_\_\_  
**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

### Application for Reinstatement of Dental Radiation Technologist

#### Checklist

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

- 1. Is your application completed front and back?
  - Did you sign and have the application notarized? **You can find a notary at any bank, post office or printing and shipping business, or on-line notary directories.**
- 2. Did you enclose the \$118.00 non-refundable fee in a check or money order made payable to the Maryland State Board of Dental Examiners?
- 3. Did you enclose proof of 8 classroom hours of dental continuing education Radiation Refresher course?
- 4. Did you enclose proof of a 2-hour Board-approved course on infection control, which may be taken in a classroom or on-line.
- 5. Did you enclose a written explanation if you answered "YES" to any question(s) in Section III Character and Fitness?
- 6. Did you enclose a notarized statement, indicating whether you have practiced dental radiation technology, which is the placement or exposure of dental radiographs? If yes, please include the month, day and year.
- 7. Did you enclose documentation of legal name change (i.e. marriage certificate, divorce decree, legal name change) if the documents sent with the application are in another name?

## **MARYLAND STATE BOARD OF DENTAL EXAMINERS GUIDELINES FOR REINSTATEMENT OF EXPIRED DENTAL RADIATION TECHNOLOGIST CERTIFICATE**

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.

### **Reinstatement of Dental Radiation Technologist Certification**

**An individual holding an expired certificate to practice dental radiation technology may apply for reinstatement if the applicant:**

- (1) Completes a dental radiation technology reinstatement application; and
- (2) Provides proof of completion of 8 classroom hours of dental continuing education from Board-approved course, 4 hours of which must be in radiology and in addition, proof of completion of a 2-hour Board-approved course on infection control; and
- (3) Provides a notarized statement, indicating whether you have practiced dental radiation technology, which is the placement or exposure of dental radiographs. If yes, please include the month, day and year.
- (4) Pays to the Board a certification reinstatement fee of \$118.00.

**To apply for reinstatement of certification, submit the Application for Reinstatement of Dental Radiation Technologist Certificate and enclose the following with your application:**

- *A \$118 non-refundable fee.*
- *Proof of completion of 8 classroom hours of continuing education, 4 hours of which shall be in radiology and in addition, proof of completion of a 2-hour Board-approved course on infection control, which may be taken in a classroom or on-line. The course(s) must have been completed within one year preceding the date of your application for reinstatement.*
- *Did you enclose a notarized statement, indicating whether you have practiced dental radiation technology, which is the placement or exposure of dental radiographs? If yes, please include the month, day and year.*

### ***Before submitting your application...***

1. Is your application completed front and back?
2. Did you sign and have the application notarized?
3. Did you enclose a check or money order in the amount of \$118.00 made payable to the Maryland State Board of Dental Examiners?
4. Did you enclose proof of continuing education? (2-hour Board-approved course on infection control, 8 classroom hours of dental continuing education radiation refresher course)
5. Did you enclose a notarized statement, indicating whether you have practiced dental radiation technology, which is the placement or exposure of dental radiographs? If yes, please include the month, day and year.
6. If you have changed your name, did you enclose proof of legal name change such as a marriage certificate, divorce decree, or other court document?
7. Did you enclose a written explanation if you answered "YES" to any question(s) in Section III Character and Fitness?

**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  
ATTN: Licensing Unit