Maryland State Board of Dental Examiners
Spring Grove Hospital Center • Benjamin Rush Building
55 Wade Avenue
Catonsville, Maryland 21228
(410) 402-8501

APPLICATION TO PARTICIPATE IN AN ADVANCED CLINICAL TRAINING PROGRAM FOR CONTINUING EDUCATION TO BE HELD AT THE UNIVERSITY OF MARYLAND DENTAL SCHOOL

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 held at the University of Maryland Dental School. If you hold an active general license to practice dentistry in Maryland, you should not compete 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 at the University of Maryland Dental School. 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. 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 MD, 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 (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. Home Phone Number: ☐☐☐-☐☐☐-☐☐☐☐

D. Work Phone Number: ☐☐☐-☐☐☐-☐☐☐☐

E. E-Mail Address:

F. Licensure:
List all states or jurisdictions in which you hold a dental license. Include license number(s).

State	License Number	Expiration Date

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

SECTION II – ADVANCED CLINICAL TRAINING PROGRAM

A. Title of advanced clinical training program: _____

B. Dates of program: _____

C. Number of continuing education hours: _____

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 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?

❒ ❒ 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 entity?

❒ ❒ c. Has your application for a dentist license 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, 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. Are there any criminal charges against you in any court of law, excluding minor traffic violations?

❒ ❒ i. Do you have a physical or mental condition that currently impairs your ability to practice dentistry?

❒ ❒ j. Has the use of drugs and/or alcohol resulted in an impairment of your ability to practice your profession?

❒ ❒ k. Do you illegally use drugs?

❒ ❒ l. 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 entity?

❒ ❒ m. Have you been named as a defendant in a filing or settlement of a malpractice action?

❒ ❒ n. 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 held at the University of Maryland Dental School 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 held at the University of Maryland Dental School.

_____ _____

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