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

APPLICATION FOR CERTIFICATION AS A DENTAL ASSISTANT QUALIFIED IN ORTHODONTICS

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. 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.

Information for Veterans, Service Members, and Military Spouses

Please note the following:

"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 a 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.

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.

Are you a:

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 orthodontics 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

Law requires certificate holders to notify the Board	
Street Address:	
City, State, Zip:	

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 <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.)

H. Licensure in other states:
List other states or jurisdiction in which you hold 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**

❒ ❒ a. Has any licensing or disciplinary board of any jurisdiction, including Maryland, or any federal entity denied your application for registration, 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?

SECTION III - CHARACTER AND FITNESS (CONT'D)

YES	NO	
❒	❒	c. Has your application for a dental assistant qualified in orthodontic expanded functions 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, 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. 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 as a dental assistant qualified in orthodontic expanded functions?
❒	❒	j. Do you have a mental health condition that impairs your ability to practice as a dental assistant qualified in orthodontic expanded functions?
❒	❒	k. Have the use of drugs and/or alcohol resulted in an impairment of your ability to practice as a dental assistant qualified in orthodontic expanded functions?
❒	❒	l. Have you illegally used drugs?
❒	❒	m. Have you surrendered or allowed your registration 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 800-974-0068 or visit the website at www.mdhawell-being.org.

SECTION IV – REQUIREMENTS FOR CERTIFICATION

❒ a. Education: Attach documentation substantiating proof of completion of a Board- approved educational program in dental assisting orthodontics of at least 35 hours . Please submit either 1) a copy of a certificate indicating that you have successfully completed a Board-approved course that included at least 35 hours of training in dental assisting orthodontics; or 2) a letter from an educational institution indicating that you have successfully completed a course that included at least 35 hours of training in dental assisting orthodontics. The original letter should be on letterhead of the institution and bear an original signature.

Note: **This instruction is for veterans and service members**. If you are a veteran or service member you may meet the requirement if you have completed a training and education program in the military that included training and education in dental assisting orthodontics of at least 35 hours, if the Board determines that 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 indicating that you have successfully completed a course that included at least 35 hours of training in dental assisting orthodontics; or 2) a letter from either your commanding office 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 orthodontics. The original letter should be on letterhead and bear an original signature.

❒ b. Provide one (1) photo that is between 2x2-inches and 3x3-inches with the required notarized affidavit. Note that the photo will be affixed to your registration. The photo must meet the following guidelines: taken within the last 2 years to reflect your current appearance; front view of full face from top of hair to shoulders; a natural expression; no hat or head covering that obscures the hair or hairline, unless worn daily for religious purposes; no sunglasses, headphones, wireless hands-free devices or similar items; no other individuals or distractions in the photo. Photos copied or digitally scanned from driver's licenses or other official documents are not acceptable. In addition, low quality vending machine or mobile phone photos are not acceptable. "Passport" photos are acceptable. Unacceptable photos will be returned and may delay the issuance of your registration.

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 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 Dental Assistant Qualified in Orthodontics 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.

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Applicant Signature **Date**