

**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 DENTAL RADIATION TECHNOLOGIST CERTIFICATION
BY WAIVER OF EXAMINATION**

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, State Gov't Article, §10-617, 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 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 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 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):	
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 all 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 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? |

SECTION III - CHARACTER AND FITNESS (CONT'D)

YES NO

- | | | |
|--------------------------|--------------------------|---|
| <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? |
| <input type="checkbox"/> | <input type="checkbox"/> | 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? |
| <input type="checkbox"/> | <input type="checkbox"/> | n. Have you been named as a defendant in a filing or settlement of a malpractice action? |
| <input type="checkbox"/> | <input type="checkbox"/> | 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.

SECTION IV – REQUIREMENTS FOR CERTIFICATION

- ☐ a. Licensure or Certification. Attach documentation substantiating that you hold a license or certification to practice dental radiation in another state.
- ☐ b. Active Practice. Attach a notarized statement from one or more employers attesting that you have actively practiced dental radiation technology for at least 150 hours in the 3 years preceding the date of this application.

Note that the practice of dental radiation technology in the armed forces and the practice of dental radiation technology in state and federal programs within the 3 years preceding application counts toward the required hours of active practice.

- ☐ c. 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 certificate. 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 certificate. **(See attached photo affidavit)**

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 Annotated Code of Maryland, Health Occupations §4-315.

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

Revised: 1/11/2017



STATE OF MARYLAND

DHMH Maryland State Board of Dental Examiners

Maryland Department of Health and Mental Hygiene

Spring Grove Hospital Center • Benjamin Rush Building

55 Wade Avenue/Tulip Drive • Catonsville, Maryland 21228

Larry Hogan, Governor – Boyd Rutherford, Lt. Governor – Dennis R. Schrader, Secretary

PICTURE

*Please provide (1) photo that is between 2x2 and 3x3 inches.

This is a true photo of myself taken within the last 2 years to reflect my current appearance. In addition, the photograph complies with the photograph requirements contained in my 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

MARYLAND STATE BOARD OF DENTAL EXAMINERS

Application for Dental Radiation Technologist Certification by Waiver of Examination

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?
- ☐ 2. Did you enclose one photo that is between 2x2 inches and 3x3 inches with the required notarized affidavit? **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 certificate.**
- ☐ 3. Did you enclose proof of completion of a Board-approved educational program in dental radiation technology of at least 24 hours?
- ☐ 4. Did you enclose certified letters with the state seal affixed from each state from which you hold have ever held a certificate, verifying that the certificate is or was in good standing and that no disciplinary action has ever been taken against the certificate.
- ☐ 5. Did you enclose a notarized statement from a former employer showing proof of active practice of at least 150 hours in the last 3 years preceding the date of this application?
- ☐ 6. Did you enclose a written explanation if you answered "YES" to any question(s) in Section III Character and Fitness?
- ☐ 7. Did you enclose documentation of legal name change (i.e. marriage certificate) if the documents sent with the application are in another name?

MAIL APPLICATION AND SUPPORTING DOCUMENTS TO:

Maryland State Board of Dental Examiners
The Benjamin Rush Building
Spring Grove Hospital Center
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Catonsville, MD 21228
ATTN: Licensing Unit