MISSISSIPPI STATE BOARD OF DENTAL EXAMINERS

Suite 100 ● 600 East Amite Street ● Jackson, MS ● 39201-2801 ● 601-944-9622 ● www.dentalboard.ms.gov

M E M O R A N D U M

TO: **DENTISTS REQUESTING LICENSURE THROUGH CREDENTIALING**

FROM: **DIANE HOWELL, DIRECTOR**

SUBJECT: **APPLICATION PACKET AND CHECKLIST** **Upated March 4, 2012**

Attached to this memorandum are (1) an Application for Licensure by Credentials to Practice Dentistry; and (2) the laws and regulations pertaining to the practice of dentistry in the State of Mississippi. The purpose of this memorandum is to reiterate information contained in the Application and to provide you with a checklist to ensure a completed Application prior to submission to the Mississippi State Board of Dental Examiners. Additionally, this Application packet is valid for ninety (90) days from the date of mailing. If the Board does not receive a signed, completed Application and the appropriate fee during this time, you must request a new Application packet and complete it accordingly.

1. Your fee for licensure through credentialing is $2,500.00, and this fee is non-refundable. Payment must be in the form of a certified check or money order.

2. All Applications must be typed and mailed by certified mail, return receipt requested, to the above address. Incomplete Applications will be returned to the applicant.

3. It is at the sole discretion of this Board to grant licensure, and the filing of this Application, along with the payment of the $2,500.00, in no way guarantees approval of licensure.

4. A dentist licensed by this Board must practice a minimum of three (3) months per year in Mississippi to remain on active status, and the three (3) months do not need to be consecutive. Board Regulation 49 defines three (3) months as being one (1) day per month for any three (3) months of the preceding license renewal period.

5. All questions must be answered fully, truthfully, and accurately; if, however, a question does not pertain to you, so indicate by typing "N/A" in the space provided. If additional space is needed to respond to certain questions, please put your response on plain white paper and number your response to correspond with the question on the Application. The Board encourages you to provide as much detail as possible. All requested supporting data must be received by the Director of this Board.

6. You must provide a written statement indicating that you will appear, at your own expense, before this Board for a personal interview, and this Board must have a completed Application and all supporting information prior to scheduling an interview.

7. You must provide sworn statements/affidavits from all employers noting dates and types of employment during the past five (5) years. If you have been self-employed during this time, prepare a sworn statement/affidavit noting dates and types of businesses owned/operated.

8. You are required to have all colleges/universities and dental schools attended mail certified copies of the appropriate transcripts directly to this Board.

9. You are required to have the Joint Commission on National Dental Examinations mail certified copies of your National Board grade cards directly to this Board.

10. You must make a self-query from the National Practitioner Data Bank (NPDB) and Healthcare Integrity and Protection Data Bank (HIPDB), and the original of this form must be forwarded to this Board's office.

11. You are required to have the state dental licensing board for all states in which you currently are, or have ever been, licensed to mail certifications regarding your status, disciplinary actions, any reasons for licensure revocation or suspension, etc., directly to this Board.

12. Proof of professional liability insurance coverage and that such coverage has not been refused, declined, canceled, non-renewed, or modified may be mailed with your Application or submitted to this Board by the insurance carrier.

13. Proof of participation in continuing education programs and certification in Cardiopulmonary Resuscitation should be mailed with the Application.

14. The names, addresses, and telephone numbers of three (3) patients treated within the previous six (6) months should be mailed with the Application.

15. You will be required to successfully complete a jurisprudence examination based on the Mississippi Dental Practice Act and the Mississippi State Board of Dental Examiners rules and regulations.

APPLICATION CHECKLIST

- ☐ Application form completed; picture included
- ☐ Certified check or money order for $2,500.00 included with Application
- ☐ Written statement agreeing to Board interview provided
- ☐ Sworn statements/affidavits from all employers during the past five (5) years
- ☐ Certification(s) from board of dental examiners in state(s) where applicant has ever been licensed, or is currently licensed, to practice dentistry requested
- ☐ Transcript(s) from college(s) and/or university(ies) requested
- ☐ Transcript(s) from dental school(s) requested
- ☐ Testimonials of Moral Character provided
- ☐ Certification of Intent completed
- ☐ Proof of continuing education provided
- ☐ Proof of Cardiopulmonary Resuscitation provided
- ☐ Proof of liability insurance coverage provided/requested
- ☐ National Board examination grades requested
- ☐ NPDB and HIPDB information requested
- ☐ Names, addresses, and telephone numbers of three (3) patients treated within the previous six (6) months provided
- ☐ Mississippi jurisprudence examination material reviewed

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APPLICATION FOR LICENSURE BY CREDENTIALS TO PRACTICE DENTISTRY

An unmounted bust photo not less than 2½" x 2½" of applicant taken not more than six months prior to date of application. Photo must be securely attached to this space.

APPLICATION MUST BE TYPEWRITTEN

This Application must be typewritten and mailed within ninety (90) days by certified mail, return receipt requested, to the above address, and all fees must be paid by money order or certified check and are NON-REFUNDABLE. Applications must be complete before an interview is scheduled before the Board, and incomplete Applications will be returned to the applicant. Each question must be answered fully, truthfully, and accurately. If a request for information is not applicable to you, so state by marking "N/A." If an explanation is required and there is not sufficient space provided, please put your response on plain white paper and number your response to correspond with the question on this Application. All requested supporting data must be received by the Director of this Board.

I hereby make application for issuance of a license by credentials to practice dentistry in the State of Mississippi, all in accordance with and subject to the rules and regulations of the Mississippi State Board of Dental Examiners and the laws governing the practice of dentistry in the State of Mississippi. I further understand that I must practice a minimum of three (3) months per year in the State of Mississippi to remain active and that the three (3) months do not need to be consecutive (see memorandum).

First Name _____ Middle Name _____ Maiden Name _____ Last Name _____

Social Security Number _____ Race _____ Sex _____ Height _____ Weight _____

City and State of Birth _____ Country of Birth _____ Date of Birth _____ Age _____

Current Residence Address (STREET ONLY) _____ City _____ State _____ Zip Code _____

Current Office Address (STREET ONLY) _____ City _____ State _____ Zip Code _____

Current Mailing Address (STREET OR POST OFFICE) _____ City _____ State _____ Zip Code _____

Residence: Telephone Number _____ Fax Number _____ Office: Telephone Number _____ Fax Number _____

Dental School Graduated From _____ Date _____ Degree _____

(THIS SECTION FOR MSBDE USE ONLY)

☐ Application Form Received ☐ Application Fee Received ☐ U. S. Citizen ☐ Yes ☐ No
☐ Proof of CPR ☐ Proof of Liability Insurance ☐ Proof of Continuing Education
☐ Statement Agreeing to Interview ☐ NPDB, HIPDB, AADB Reports ☐ Investigator Checked Application
☐ National Board Grade Scores ☐ Part I_____ Date _____ ☐ Part II_____ Date_____
☐ Sworn Statements from Employers for Past 5 Years_____
☐ Names/Addresses/Telephone Numbers of 3 Patients_____
☐ College Transcript(s)_____
☐ Dental School Transcript(s)_____
☐ Testimonials of Moral Character_____
☐ State Board Certifications of Licensure_____
☐ Passed Jurisprudence Examination Date_____Examination Score_____
☐ Approved by Board Interview Date_____License Number_____Date Issued_____

PERSONAL AND PROFESSIONAL

1. Are you a citizen of the United States of America? ☐ Yes ☐ No
2. Are you (check one) ☐ Single ☐ Married ☐ Divorced
3. If married, Male: Maiden name of spouse and address before marriage

   Female: Name of spouse and address before marriage
4. Are you in good health? ☐ Yes ☐ No **If no, explain any illness or infirmity on attached sheet of paper.**
5. Give a brief history of your activities for the past ten (10) years, including times as a full-time student, service in the Armed Forces of the United States, practice of dentistry in all states, and other occupations. **Provide sworn statements/affidavits noting dates and types of employment from all employers during the past five (5) years. If you have been self-employed during this time, prepare a sworn statement/affidavit noting dates and types of businesses owned/ operated.**
6. Do you confine your practice of dentistry to a specialized area? ☐ Yes ☐ No If yes, state your specialty.
7. Have you ever practiced dentistry in the State of Mississippi? ☐ Yes ☐ No **If yes, explain fully with the dates and locations on attached sheet of paper.**
8. Do you intend to adhere to the A.D.A. standards of conduct for practicing dentistry? ☐ Yes ☐ No
9. Have you ever failed licensure examinations given by this Board, another state board, or a regional board? ☐ Yes ☐ No **If yes, state which examinations, parts, and dates.**
10. Have you ever been refused licensure examinations given by this Board, another state board, or a regional board? ☐ Yes ☐ No **If yes, state which examinations, parts, and dates.**
11. List all states in which you are currently and have ever been licensed to practice dentistry.

    The Secretary of the Board of Dental Examiners in each state in which you are currently licensed must provide this Board with a certified statement of your license status and good standing. In states where you previously have been licensed, the Secretaries of those Boards must provide this Board with a certified statement of your license expiration or revocation.
12. Are you certified by the National Board of Dental Examiners? ☐ Yes ☐ No If yes, please provide your reference number. _____ **A copy of the grade card must be sent directly to the Board by the Joint Commission on National Dental Examinations. To have your grade card mailed to this Board's office, you may contact the Joint Commission at telephone number 1-800-621-8099.**
13. Have you ever failed any part or parts of the National Board? ☐ Yes ☐ No **If yes, state which part or parts and give dates.**
14. Do you currently hold a Federal DEA Number to administer, prescribe, or dispense controlled substances? ☐ Yes ☐ No If yes, provide your current registration number._____ Have you ever surrendered your DEA number or had it revoked or restricted? ☐ Yes ☐ No **If yes, explain fully on attached sheet of paper.**
15. Have you ever been disciplined, reprimanded, placed on probation, and/or had your license suspended, cancelled, restricted, or revoked by this Board, another board, a hospital, or any professional society? ☐ Yes ☐ No Is any such disciplinary action against you currently pending before any state board, hospital, or professional society? ☐ Yes ☐ No Have you ever resigned from the medical staff of a hospital while an investigation or disciplinary hearing was being conducted? ☐ Yes ☐ No **If yes to any item, explain fully with the names, boards, reasons, dates, etc., on attached sheet of paper.**
16. Have you ever been a party to any malpractice claims, demand, or suits? ☐ Yes ☐ No Are any such suits currently pending? ☐ Yes ☐ No Have you ever been denied malpractice insurance? ☐ Yes ☐ No **If yes to any item, explain fully on attached sheet of paper. Proof of professional liability insurance coverage and that such coverage has not been refused, declined, canceled, non-renewed, or modified may be mailed with this Application or submitted to this Board's office by the insurance carrier.**
17. Have you ever been addicted to alcohol, narcotics, or any other drug having addiction-forming or addiction-sustaining liabilities and/or received treatment for such addictions? ☐ Yes ☐ No Have you ever been treated for any mental disorder? ☐ Yes ☐ No **If yes to any item, explain fully on attached sheet of paper, giving dates, names of institutions, etc., where treatment was received.**

18. Have you ever been convicted of violating federal or state laws concerning the possession, distribution, or use of controlled substances, or are any such charges currently pending against you? ☐ Yes ☐ No **If yes, explain fully on attached sheet of paper.**

19. Have you ever been arrested, convicted of a felony, or convicted of any crime, felony, or misdemeanor related to your dental practice, or are any such charges currently pending against you? ☐ Yes ☐ No **If yes, explain fully on attached sheet of paper.**

20. **Proof of participation in continuing education programs for the previous three (3) years must be provided to the Director of this Board. Proof of participation in continuing education programs should be mailed with this Application.**

21. **Proof of current certification in Cardiopulmonary Resuscitation must be provided to the Director of this Board. The practitioner may forward to this Board a copy of the current certification card, which should be included when mailing this Application.**

22. **The names, addresses, and telephone numbers of three (3) patients treated within the previous six (6) months should be mailed with this Application.**

23. **Practitioners must make a self-query from the National Practitioner Data Bank (NPDB) and Healthcare Integrity and Protection Data Bank (HIPDB). This can be done by contacting the NPDB-HIPDB at Post Office Box 10832, Chantilly, Virginia, 20153-0832. The NPDB-HIPDB's telephone number is 1-800-767-6732, and the facsimile number is 703-802-4109. The NPDB-HIPDB provides the practitioner with a form even though no reports have been filed, and the original of this form must be forwarded to this Board's office.**

24. **A written statement agreeing to appear before the Board for an interview must be included with this Application.**

EDUCATION

NOTE: Practitioner must have forwarded to the Director of this Board a transcript from each college, university, or dental school attended with subjects, grades, and dates of graduation. Proof of graduation must be presented to this Board prior to license being issued.

25. Undergraduate School or Schools Attended: | Period of Attendance and Degree Granted:

_____ College or University - Address _____

_____ College or University - Address _____

_____ College or University - Address _____

26. Dental School or Schools Attended: | Period of Attendance and Degree Granted:

_____ Dental School - Address _____

_____ Dental School - Address _____

_____ Dental School - Address _____

CERTIFICATION OF INTENT

27. Pursuant to Miss. Code Ann. § 73-9-24(1)(m)(10), I, _____, hereby certify that within _____(_____) days after issuance of a license to practice dentistry in the State of Mississippi, I will establish a permanent office for the active practice of dentistry in Mississippi. This office will be established at the following address: _____.

I intend to practice in Mississippi on a regular basis (check one):

☐ as a sole practitioner.

☐ in an association with other dentists. If so, state the name(s) and address(es) of the dentists._____

_____

☐ as an instructor at an educational facility. If so, state the name and address of the facility._____

_____

Signature_____

Typed Name_____

Typed Address_____

_____

Typed City, State, Zip_____

SWORN TO AND SUBSCRIBED BEFORE ME on this the _____ day of _____, 20_____.

_____ SEAL

Notary Public

_____ _____

State County

My Commission Expires:_____

TESTIMONIALS OF MORAL CHARACTER

28. I offer the following references from two reputable citizens of the state of which I am a resident. (If not convenient to have character references sign application, **two letters of recommendation properly notarized and mailed directly to the Director of the Board will suffice.**)

***Complete this section only if letters of recommendation are mailed directly to the Director of the Board.**

Name_____ Name_____

Address_____ Address_____

_____ _____

_____ _____

This certifies that I have been personally acquainted with _____ for _____ years, that I know _____ to be of good moral character, and hereby recommend _____ to the Mississippi State Board of Dental Examiners as entirely worthy of a license to practice dentistry in the State of Mississippi pursuant to law.

Name_____
Address_____
Street
_____
City State Zip
Signature_____

SWORN BEFORE ME AND SUBSCRIBED IN MY PRESENCE this the ____ day of _____, 20_____.
NOTARY PUBLIC_____
My Commission Expires_____
State_____
County_____ SEAL

This certifies that I have been personally acquainted with _____ for _____ years, that I know _____ to be of good moral character, and hereby recommend _____ to the Mississippi State Board of Dental Examiners as entirely worthy of a license to practice dentistry in the State of Mississippi pursuant to law.

Name_____
Address_____
Street
_____
City State Zip
Signature_____

SWORN BEFORE ME AND SUBSCRIBED IN MY PRESENCE this the ____ day of _____, 20_____.
NOTARY PUBLIC_____
My Commission Expires_____
State_____
County_____ SEAL

ACKNOWLEDGMENT

29. In addition to the foregoing, I add the following:

(a) I have read the Mississippi Dental Practice Act and Board Regulations. I solemnly declare upon my honor that if granted a license to practice dentistry in Mississippi, I will respectfully comply with any law and regulation governing the practice of dentistry in this State, and will do my best to uphold and maintain the ethics of the profession. I further declare that I have never practiced illegal dentistry in this State or any other state.

(b) I hereby grant permission to the Mississippi State Board of Dental Examiners to secure additional information concerning me or any statement in this Application from any person or any source the Board may desire. Additionally, I understand that the Board will post on its Internet web site all information it deems necessary to enable the public to verify my licensure status. I further agree to submit to questioning by the Board or any member thereof, and to substantiate my statements if desired by the Board.

(c) I have attached a money order or certified check in the amount of Two Thousand Five Hundred and No/100 Dollars ($2,500.00) made payable to the Mississippi State Board of Dental Examiners. I understand that this Application fee is non-refundable.

(d) I, _____, the applicant herein, depose and say that all facts, statements, and answers contained in this Application are true and correct; I am not omitting any information which might be of value to this Board in determining my qualifications and character, whether it is called for or not; and I agree that any falsification, omission, or withholding of information or facts concerning my qualifications as an applicant shall be sufficient to bar me from licensure in Mississippi, and such falsifications, omissions, or withholding shall serve as sufficient grounds for the suspension, cancellation, or revocation of my Mississippi Dental License even though it is not discovered until after issuance.

Name_____
Address_____
Street
_____
City State Zip
Signature_____

SWORN BEFORE ME AND SUBSCRIBED IN MY PRESENCE this the _____ day of _____, 20_____.
NOTARY PUBLIC_____
My Commission Expires_____
State_____
County_____ SEAL

Check Application