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 BY EXAMINATION**
FROM: **CHRIS L. HUTCHINSON, EXECUTIVE DIRECTOR**
SUBJECT: **APPLICATION PACKET AND CHECKLIST** **Updated March 19, 2019**

Attached to this memorandum are (1) an Application for Licensure by Examination to Practice Dentistry; (2) Candidate Address and License Information Form; and (3) the laws and regulations pertaining to the practices of dentistry and dental hygiene 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 by examination is $250.00, and this fee is non-refundable. Payment must be in the form of a certified check or money order. Applicant will immediately owe a renewal fee upon issuance.

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 $250.00, 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 brief history of all activities within the past ten (10) years including times as a full-time student, service in the Armed Forces of the United States of America, the practice of dentistry, or other occupations.

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

8. You are required to have the Joint Commission on National Dental Examinations mail a certified copy of your National Board grade card directly to this Board.

9. If you graduated from dental school prior to January 1 of the year you are submitting this Application, 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.

10. 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.

11. 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.

12. Proof of current certification in Cardiopulmonary Resuscitation should be mailed with your Application.

13. Within ninety (90) days of the date the Board receives your Application, 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, signed, and notarized; picture included
- ☐ Certified check or money order for $250.00 included with Application
- ☐ Brief history of all activities within the past ten (10) years noted on Application
- ☐ Grade cards from ADEX/NERB, SRTA, or CITA requested, if necessary
- ☐ 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
- ☐ Proof of Cardiopulmonary Resuscitation provided
- ☐ Proof of liability insurance coverage provided/requested
- ☐ National Board examination grade requested
- ☐ NPDB and HIPDB information requested, if necessary
- ☐ Mississippi jurisprudence examination material reviewed
- ☐ Driver's License and SS Card
- ☐ Grade Cards for DSE

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APPLICATION FOR LICENSURE BY EXAMINATION 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

The Mississippi State Board of Dental Examiners has agreed to accept applications for licensure by examination from those candidates successfully completing licensure examinations administered by the American Board of Dental Examiners (ADEX), North East Regional Board of Dental Examiners (NERB), Council of Interstate Testing Agencies (CITA) or Southern Regional Testing Agency (SRTA) for a maximum of five (5) years from the date of successful completion of either of these examinations.

Each question must be answered fully, truthfully, and accurately. All requested supporting data must be received by the Secretary of this Board before this application will be considered complete.

I hereby make application for issuance of a license 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.

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 _____

Permanent Residence Address (STREET OR MAILING) _____ City _____ State _____ Zip Code _____

Office Address, If Applicable (STREET ONLY) _____ City _____ State _____ Zip Code _____

Mail License to: ☐ Current Address ☐ Permanent Address ☐ Office Address

Telephone Numbers: _____ Daytime _____ Evening _____ Office

Dental School Graduated From _____ Date _____ Degree _____

(THIS SECTION FOR MSBDE USE ONLY)

☐ Application Form ☐ Application Fee ☐ License Information Form
☐ United States Citizen ☐ Yes ☐ No ☐ Proof of Liability Insurance ☐ Proof of CPR
☐ National Board Grade Scores Part I_____ Date _____ Part II_____ Date_____ ☐ Passed ☐ Failed ☐ Pending
☐ College Transcript(s) Received_____
☐ Dental School Transcript(s) Received_____ ☐ Final Grad Date_____ GPA_____
☐ Testimonials as to Moral Character_____
☐ Certifications from Secretary of Board of Dental Examiners of the State(s) in Which Applicant Has Ever Been Licensed, or Is Currently Licensed to Practice Dentistry_____
☐ NPDB, HIPDB, & AADB Reports (applicants who graduated prior to January 1)_____
☐ Jurisprudence Examination ☐ Passed ☐ Failed Date_____ Score_____
☐ Clinical Examination ☐ Passed ☐ Failed Date_____ Score_____
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.**
5. Give a brief history of activities during the past ten (10) years including times as a full-time student, service in the Armed Forces of the United States of America, the practice of dentistry, or other occupations._____

   _____
6. Did you graduate from dental school prior to January 1 of the current year? ☐ Yes ☐ No **If yes, a self-query must be made from the National Practitioners Data Bank (NPDB) and Healthcare Integrity and Protection Data Bank (HIPDB), and both submitted with the application.**
7. Have you ever taken MS, ADEX/NERB, CITA, or SRTA clinical examinations? ☐ Yes ☐ No Have you ever practiced dentistry in the State of Mississippi? ☐ Yes ☐ No **If yes to either question, provide date(s) and/or location(s). CITA or SRTA must send a copy of your grade card to the Board.**_____
8. Have you ever failed clinical examinations listed in item 7 above, or those of another state board or another regional board? ☐ Yes ☐ No **If yes, state which examinations, parts, and dates.**_____

   _____
9. Have you ever been refused clinical examinations listed in item 7 above, or those of another state board or another regional board? ☐ Yes ☐ No **If yes, state which examinations, parts, and dates.**

   _____
10. 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.
11. Are you certified by the National Board of Dental Examiners? ☐ Yes ☐ No ☐ Results Pending **If yes, DENTPIN number.**_____ **A copy of the grade card must be sent to the Board.**
12. Have you ever failed any part or parts of the National Board? ☐ Yes ☐ No **If yes, state which part or parts and give dates.**_____
13. Do you intend to adhere to the ADA standards of conduct for practicing dentistry? ☐ Yes ☐ No
14. Do you currently hold a Federal DEA Number to administer, prescribe, or dispense controlled substances? ☐ Yes ☐ No **If yes, 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, canceled, restricted, or revoked by this Board, another board, a hospital, or any professional society? ☐ Yes ☐ No **If yes, name boards, etc., reasons, and dates on attached sheet.**

16. Have you ever been a party to any malpractice claims, demands, or suits; are any such suits pending; or have you ever been denied malpractice insurance? ☐ Yes ☐ No **If yes to any item, explain fully on attached sheet of paper.**

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 or any mental disorder? ☐ Yes ☐ No **If yes, explain fully on attached sheet, giving dates, names of institutions, etc., where treated.**

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

EDUCATION

NOTE: Applicant must have forwarded to the Secretary of this Board a transcript from each college, university, or dental school attended with subjects, grades, and dates of graduation. In the event applicant is a current year graduate from dental school, **an affidavit from the Dean stating that the applicant is expected to graduate prior to examination must be mailed to the Board by the Dean.** Proof of graduation must be presented to this Board prior to license being issued.

20. Undergraduate School or Schools Attended: Period of Attendance:

_____ _____
College or University - Address

_____ _____
College or University - Address

_____ _____
College or University - Address

21. Dental School or Schools Attended: Period of Attendance:

_____ _____
Dental School - Address

_____ _____
Dental School - Address

_____ _____
Dental School - Address

TESTIMONIALS OF MORAL CHARACTER

22. 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 Secretary of the Board will suffice.**)

***Complete this section only if letters of recommendation are mailed directly to the Secretary 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 by examination 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 by examination 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

23. 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 Hundred Fifty and No/100 Dollars ($250.00) made payable to the Mississippi State Board of Dental Examiners.

(d) I will mail this application to the Secretary of the Board by registered or certified mail with return receipt requested.

(e) 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; 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 this or any future examination given by the Mississippi State Board of Dental Examiners; 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