

# MISSISSIPPI STATE BOARD OF DENTAL EXAMINERS

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

## MEMORANDUM

**TO: DENTISTS OR DENTAL HYGIENISTS REQUESTING A  
PROVISIONAL FELLOWSHIP LICENSE**

**FROM: CHRIS L. HUTCHINSON, EXECUTIVE DIRECTOR**

**SUBJECT: APPLICATION PACKET AND CHECKLIST**

Updated March 19, 2019

Attached to this memorandum are (1) an Application for Provisional Fellowship License to Practice Dentistry or Dental Hygiene; and (2) 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 provisional fellowship licensure is \$25.00, and this fee is non-refundable. Payment must be in the form of a certified check or money order. Upon issuance of licensure, you will owe a renewal fee.
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 \$25.00, in no way guarantees approval of licensure.
4. Dentists and dental hygienists practicing with a Provisional Fellowship License in the State of Mississippi are allowed to only practice at Board-approved Mississippi fellowship programs, and these dentists and dental hygienists shall not practice their respective professions in the private sector.
5. Dentists and dental hygienists 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.
6. 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.
7. 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.
8. 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.
9. You are required to have all colleges/universities and dental/dental hygiene schools attended mail certified copies of the appropriate transcripts directly to this Board.
10. 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.
11. 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.
12. You are required to have the state dental/dental hygiene 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.

13. You are required to have the director of the Board-approved Mississippi fellowship program at which you seek to practice send a letter of recommendation directly to the Board.
14. 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.
15. Proof of participation in continuing education programs and certification in Cardiopulmonary Resuscitation should be mailed with the Application.
16. The names, addresses, and telephone numbers of three (3) patients treated within the previous six (6) months should be mailed with the Application.
17. 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 \$25.00 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/dental hygiene examiners in state(s) where applicant has ever been licensed, or is currently licensed, to practice dentistry/dental hygiene requested
- Transcript(s) from college(s) and/or university(ies) requested
- Transcript(s) from dental/dental hygiene school(s) requested
- Letter of recommendation from director of fellowship program 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
- Copy of Driver's License and SS Card

# MISSISSIPPI STATE BOARD OF DENTAL EXAMINERS

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## APPLICATION FOR PROVISIONAL FELLOWSHIP LICENSE TO PRACTICE DENTISTRY OR DENTAL HYGIENE (Circle One)

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 Provisional Fellowship License to practice 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 practices of dentistry and dental hygiene in the State of Mississippi. I understand that I am allowed to only practice at a Board-approved Mississippi fellowship program, and 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
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Social Security Number	Race	Sex	Height	Weight
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City and State of Birth	Country of Birth	Date of Birth	Age
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Current Residence Address (STREET ONLY)	City	State	Zip Code
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Current Office Address (STREET ONLY)	City	State	Zip Code
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Current Mailing Address (STREET OR POST OFFICE)	City	State	Zip Code
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Residence: Telephone Number	Fax Number	Office: Telephone Number	Fax Number
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Dental/Dental Hygiene School Graduated From	Date	Degree
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### (THIS SECTION FOR MSBDE USE ONLY)

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|--|---|---|
| <input type="checkbox"/> Application Form Received   | <input type="checkbox"/> Application Fee Received     | <input type="checkbox"/> U. S. Citizen <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Proof of CPR  | <input type="checkbox"/> Proof of Liability Insurance | <input type="checkbox"/> Proof of Continuing Education  |
| <input type="checkbox"/> Statement Agreeing to Interview   | <input type="checkbox"/> NPDB, HIPDB, AADB Reports    | <input type="checkbox"/> Investigator Checked Application                                       |
| <input type="checkbox"/> National Board Grade Scores   | <input type="checkbox"/> Part I _____ Date _____      | <input type="checkbox"/> Part II _____ Date _____   |
| <input type="checkbox"/> Sworn Statements from Employers for Past 5 Years _____                        |   |   |
| <input type="checkbox"/> Names/Addresses/Telephone Numbers of 3 Patients _____                         |   |   |
| <input type="checkbox"/> College Transcript(s) _____   |   |   |
| <input type="checkbox"/> Dental/Dental Hygiene School Transcript(s) _____                              |   |   |
| <input type="checkbox"/> Recommendation from Program Director _____                                    |   |   |
| <input type="checkbox"/> Testimonials of Moral Character _____   |   |   |
| <input type="checkbox"/> State Board Certifications of Licensure _____                                 |   |   |
| <input type="checkbox"/> Passed Jurisprudence Examination Date _____ Examination Score _____           |   |   |
| <input type="checkbox"/> 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 or dental hygiene 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.**  
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6. Have you ever practiced dentistry/dental hygiene in the State of Mississippi?  Yes  No **If yes, explain fully with the dates and locations on attached sheet of paper.**
7. Do you intend to adhere to the A.D.A./A.D.H.A. standards of conduct for practicing?  Yes  No
8. 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.**\_\_\_\_\_
9. 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.**\_\_\_\_\_
10. List all states in which you are currently and have ever been licensed to practice dentistry/dental hygiene.\_\_\_\_\_

**The Secretary of the Board of Dental/Dental Hygiene 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 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.**
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 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.**
14. 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.**
15. 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.**
16. 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.**



