# 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 OR DENTAL HYGIENISTS REQUESTING A VOLUNTEER/LIMITED PROVISIONAL LICENSE**

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

**SUBJECT:** **APPLICATION PACKET AND CHECKLIST** **Updated November 05, 2020**

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Attached to this memorandum is (1) an Application for a Volunteer/Limited Provisional 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 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 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 Volunteer or Limited Provisional License in the State of Mississippi are allowed to only provide charitable and gratuitous dental services in charitable clinics (whether stationary, portable, or mobile), and these dentists and dental hygienists shall not practice their respective professions in the private sector.

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 notarized 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 notarized statement/affidavit noting dates and types of businesses owned/operated.

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

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

9. 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.

10. 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.

11. Proof of certification in Cardiopulmonary Resuscitation should be mailed with the Application.

# APPLICATION CHECKLIST

- ☐ Application form completed; picture included
- ☐ Certified check or money order for $25.00 included with Application
- ☐ Notarized 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 dental/dental hygiene school(s) requested
- ☐ Testimonials of Moral Character provided
- ☐ Certification of Intent completed
- ☐ Proof of Cardiopulmonary Resuscitation provided
- ☐ Proof of liability insurance coverage provided/requested
- ☐ NPDB information requested
- ☐ Copy of Driver's License and SS Card

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## APPLICATION FOR A VOLUNTEER/LIMITED PROVISIONAL 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 Volunteer/Limited Provisional 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 in .... itable clinics, (whether stationary, portable, or mobile).

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/Dental Hygiene School Graduated From | Date | Degree

## (THIS SECTION FOR MSBDE USE ONLY)

- ☐ Application Form Received
- ☐ Application Fee Received
- ☐ Proof of CPR
- ☐ Proof of Liability Insurance
- U.S. Citizen ☐ Yes ☐ No
- ☐ Approved by Board
- ☐ Sworn Statements from Employers for Past 5 Years
- ☐ Dental/Dental Hygiene School Transcript(s)_____
- ☐ Testimonials of Moral Character_____
- ☐ State Board Certifications of Licensure_____
- ☐ NPDB & AADB Reports
- ☐ Investigator Checked Application

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 five (5) 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 notarized 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 notarized statement/affidavit noting dates and types of businesses owned/operated.**

   _____

   _____

   _____

   _____

   _____

   _____

   _____
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. 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.**
9. 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.**
10. 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 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.**
11. Have you ever been a party to any malpractice claims, demand, or suites? ☐ Yes ☐ No Are any such suites 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.**
12. 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.**
13. 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.**
14. Have you ever been arrested, convicted of a felony, or convicted of any crime, felony, or misdemeanor related to your dental or dental hygiene practice, or are any such charges currently pending against you? ☐ Yes ☐ No **If yes, explain fully on attached sheet of paper.**
15. **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.**
16. **Practitioners must make a self-query from the National Practitioner Data Bank (NPDB). This can be done by contacting the NPDB at Post Office Box 10832, Chantilly, Virginia, 20153-0832. The NPDB's telephone number is 1-800-767-6732, and the facsimile number is 703-802-4109. The NPDB 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.**

## EDUCATION

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

17. Dental/Dental Hygiene School or Schools Attended: Period of Attendance and Degree Granted:

_____ _____
Dental/Dental Hygiene School - Address

_____ _____
Dental/Dental Hygiene School - Address

_____ _____
Dental/Dental Hygiene School - Address

## CERTIFICATION OF INTENT

18. Pursuant to Miss. Code Ann. § 73-9-28 and Board Regulation 7, I,_____, hereby certify that within _____(_____) days after issuance of a Volunteer/Limited Provisional License to practice in the State of Mississippi, I will provide charitable and gratuitous dental services in charitable clinics (whether stationary, portable, or mobile). The names and addresses of the charitable clinics are as follows: _____

_____

_____

Signature _____

Typed Name _____

Typed Address _____

_____

Typed City, State, Zip _____

SWORN TO AND SUBSCRIBED BEFORE ME on the

_____ day of _____, 20_____.

_____ SEAL
Notary Public

_____ _____
State County

My Commission Expires: _____

## TESTIMONIALS OF MORAL CHARACTER

19. 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 Volunteer/Limited Provisional License to practice in the State of Mississippi pursuant to law.

Printed Name_____

Address_____

_____

_____

Signature_____

SWORN TO AND SUBSCRIBED BEFORE ME on 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 Volunteer/Limited Provisional License to practice in the State of Mississippi pursuant to law.

Printed Name_____

Address_____

_____

_____

Signature_____

SWORN TO AND SUBSCRIBED BEFORE ME on the _____day of _____ 20_____

NOTARY PUBLIC_____

My Commission Expires_____

State_____

County_____ SEAL

## ACKNOWLEDGMENT

20. 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 Volunteer/Limited Provisional License to practice in Mississippi, I will respectfully comply with any law and regulation governing the practices of dentistry/dental hygiene 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 illegally 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 Twenty-Five and No/100 Dollars ($25.00) 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 Volunteer/Limited Provisional License even though it is not discovered until after issuance.

Printed Name_____

Address_____

_____

_____

Signature_____

SWORN TO AND SUBSCRIBED BEFORE ME on the _____day of _____ 20_____

NOTARY PUBLIC _____

My Commission Expires _____

State_____

County _____ SEAL