Louisiana State Board of Dentistry
365 Canal Street ~ Suite 2680
New Orleans, Louisiana 70130
504.568.8574 Telephone ~ 504.568.8598 Fax
www.lsbd.org

Dental License by Examination

General Information

Please find included an application for a dental license by examination, an HIV/HBV/HCV reporting form (to be completed **only** if you have tested positive), and a copy of the rules governing the application for a dental license by examination. You must also contact our office to have fingerprint cards and forms sent to you as these materials cannot be downloaded from our website.

The dental license by examination application fee is $400.00 and is **non-refundable**.

In addition to this application, you must also successfully complete a jurisprudence examination covering the Louisiana Dental Practice Act (a copy of which may be found on our website). You must contact the board office to arrange to take the jurisprudence examination. Examinations are given at the board office Tuesdays and Thursdays between 10:00 AM and 2:00 PM. **DO <u>NOT</u> CONTACT THE BOARD TO SCHEDULE YOUR JURISPRUDENCE TEST UNTIL YOUR APPLICATION, FEE, AND FINGERPRINT BACKGROUND CHECK INFORMATION HAVE ALREADY BEEN SENT TO THE BOARD OFFICE.**

It is at the sole discretion of this board to grant licensure, and the filing of this application, along with the $400.00 fee, in no way guarantees approval of licensure.

Incomplete applications will be returned to the applicant.

IMPORTANT NOTE REGARDING THE ACCEPTANCE OF REGIONAL CLINICAL LICENSING EXAMINATIONS

Applicants who completed a clinical licensing examination ***between January 1, 2009 and December 31, 2011:***

The Louisiana State Board of Dentistry accepts clinical licensure examination results from all regional testing agencies (CITA, CRDTS, SRTA, WREB, NERB, and ADEX) if the examination was successfully completed prior to December 31, 2011. **You must apply for a Louisiana dental license by examination within three years of your successful completion of the clinical licensing examination.** If you completed your regional examination prior to three years from the date we receive your application, you will not be eligible for a Louisiana dental license by examination, and you will be required to apply for a license by credentials. (For more information regarding a license by credentials, please contact our office.)

Applicants completing a clinical licensing examination
after December 31, 2011:

The Louisiana State Board of Dentistry **only** accepts clinical licensure examination results from CITA. No other clinical licensure examination scores will be accepted if the applicant completes the licensure examination after December 31, 2011. **You must apply for a Louisiana dental license by examination within three years of your successful completion of the CITA examination.** If you completed your CITA examination prior to three years from the date we receive your application, you will not be eligible for a Louisiana dental license by examination, and you will be required to apply for a license by credentials. (For more information regarding a license by credentials, please contact our office.)

Instructions

Your application must be completed fully, truthfully and accurately. If a particular question does not apply to you, mark "N/A" in the appropriate space. If you need more information to answer any question(s), complete your answer on an additional sheet of paper and attach it to your application.

You must include the $400.00 application fee. The board accepts checks and money orders only. Credit card or cash payments are not accepted.

You must attach one recent passport size color photograph to your application.

You must include an original or certified true copy of your birth certificate or other documentation of your U.S. citizenship. If you are eligible under NAFTA, you must submit a certified true copy of the appropriate documentation. **Any documents you send to the Louisiana State Board of Dentistry will not be returned.** For this reason, it is strongly recommended that you do not send an original birth certificate. You may contact the office of vital statistics in your birth state to have a certified true copy sent to you.

You must include a copy of your current CPR card. The courses the Louisiana State Board of Dentistry accepts are the American Heart Association Healthcare Provider Course or the American Red Cross Professional Rescue Course or their equivalent. Online CPR courses are not acceptable.

You must request the ADA to send an original score card of your national board results directly to the Louisiana State Board of Dentistry.

You must request the regional testing agency that administered your clinical licensing examination to send your results directly to the Louisiana State Board of Dentistry.

You must have section 5B of the application signed and sealed by your dental school.

You must have each board of dentistry where you currently hold or have ever held a dental license send a certification directly to the Louisiana State Board of Dentistry. This only applies if you have ever had a dental license in another state.

Your application must be notarized prior to your submitting it to the board.

You must include completed fingerprint cards and forms with your submitted application unless other arrangements have been made previously with the board office.

Additionally, there may be requirements from your clinical testing agency before they will send our office proof of your successful completion. For example, CITA will not notify us that you have attained CITA status unless and until they have first received your national board scores. Be sure to read your testing agency's examination manual.

The board office will notify you of any deficiencies in your application. Calling the board on a daily basis hinders the processing of your application.

PROCESSING OF LICENSURE APPLICATIONS WILL TAKE A MINIMUM OF EIGHT TO TWELVE WEEKS. PLEASE DO **NOT** CALL THE BOARD OFFICE FOR A RUSH REQUEST AS THIS IS IMPOSSIBLE.

PHOTOGRAPH OF APPLICANT	FOR OFFICE USE ONLY	
An unmounted color passport type bust photograph, 2 1/2"x 2 1/2", taken not more than six months before date of application, must be securely pasted (NOT STAPLED) to this space and must not be larger than space provided. (No hats or caps, please.)	Fee paid ______ National board scores ______ CPR ______ Photograph ______ Proof of citizenship ______ Fingerprints ______	Jurisprudence ______ Dean signature/seal ______ Regional exam ______ Other state certifications ______ License number issued ______ Date Issued ______

LOUISIANA STATE BOARD OF DENTISTRY

APPLICATION FOR DENTAL LICENSE BY EXAMINATION

APPLICATION FEE (NON-REFUNDABLE) $400.00

Instructions for the applicant:
Print legibly or use a typewriter to provide the following information. If the space for any answer is insufficient, you must complete your answer on a rider, specifying the number of the question to which it relates, sign it, and enclose it with this application. You must attach one current, autographed (on the back) passport size photograph. You must also include a copy of your current CPR card and an original or certified true copy of your birth certificate or other documentation to show citizenship or permanent resident status (or eligibility under NAFTA).

1. APPLICANT PROFILE DATA

A. WHICH CLINICAL LICENSING EXAMINATION DID YOU COMPLETE? ______ B. DATE COMPLETED ______

C. NAME ______
Last First Middle

D. SOCIAL SECURITY NUMBER ______

E. CITIZEN OR PERMANENT RESIDENT OF U.S. ☐ Yes ☐ No

F. MAILING ADDRESS ______
Street and Number Apt. No. City, State ZIP

G. HOME ADDRESS ______
Street and Number Apt. No. City, State ZIP

H. HOME PHONE ______ CELL PHONE ______

Have you ever changed your name through marriage or through action of the court, or have you ever been known by any other name? ☐ Yes ☐ No. If yes, list name(s), and reason for change below. If by court order, enclose herein a certified copy of such order.

I. OTHER NAMES ______

J. DATE OF BIRTH ______ AGE: ______ PLACE OF BIRTH ______

K. SEX ______ HEIGHT ______ WEIGHT ______ RACE ______ BUILD ______

EYE COLOR ______ HAIR COLOR ______ COMPLEXION ______

IDENTIFYING MARKS ______

L. MARITAL STATUS: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

M. SPOUSE If married, give spouse's full name: ______________________
(If woman, give maiden name)

N. FATHER ______________________
Full Name Street and Number City, State ZIP

O. MOTHER ______________________
Full Name Street and Number City, State ZIP

2. APPLICANT EDUCATION DATA

A. **COLLEGE OR UNIVERSITY EDUCATION**
(as separate from 4 year dental education)

Name and Location of Institution	**Period of Attendance**
1st Year	
2nd Year	
3rd Year	
4th Year	

Number of hours received for college or university work: ______________________

Degree received for college or university work: ______________________

School within college or university awarding degree:
(i.e. School of Arts and Sciences—Mathematics) ______________________

Date degree was awarded: ______________________

Name of college or university awarding degree: ______________________

B. **DENTAL EDUCATION**

Name and Location of Institution	**Period of Attendance**
1st Year	
2nd Year	
3rd Year	
4th Year	

C. **POST GRADUATE EDUCATION**

Name and Location of Institution	**Period of Attendance**
1st Year	
2nd Year	
3rd Year	

Completed specialty program? ☐ Yes ☐ No Specialized in: ______________________

Have you ever held yourself out as being a specialist in any branch of dentistry? ☐ Yes ☐ No

If yes, give branch: ______________________ Are you a diplomate of a specialty board? ☐ Yes ☐ No

If yes, give name of specialty board and date of certification ______________________

D. **INDICATE BELOW ALL TIME SPENT IN INTERNSHIP OR RESIDENCY**

Hospital or Other Institution	**Location**	**Period of Attendance**
1.		
2.		

Type of internship or residency: ______________________

3. APPLICANT HISTORY—GENERAL

A. Have you ever been convicted or found guilty—regardless of adjudication—of a crime in any jurisdiction? (Do not include parking or speeding violations.) ☐ Yes ☐ No

B. Branch of armed forces served in: ______________________ Date separated: ____________

If separated, attach a copy of discharge.

Have you ever been a defendant in a military court martial or received a dishonorable discharge? ☐ Yes ☐ No

**If answer to 3A or 3B is yes, please list date, jurisdiction (state and parish), offense, disposition, and all other relevant information on a rider.*

C. Have you ever been declared legally incompetent? ☐ Yes ☐ No

**If yes, please explain on a rider including full details as to court, date, circumstances, and medical practitioners consulted.*

D. Have you been addicted or received treatment for the use of drugs, narcotics, or intoxicating liquors within the past five (5) years? ☐ Yes ☐ No

E. Are you presently afflicted with an incurable or recurring contagious or infectious disease? ☐ Yes ☐ No

F. Have you received regular treatment for amnesia, emotional disturbances, or mental disorder within the past five (5) years? ☐ Yes ☐ No

**If 3D, 3E, or 3F above is answered yes, please show on a rider the relevant dates and circumstances of such treatment, along with the names and addresses of the medical practitioners who treated you. In addition, it will be necessary for you to direct each of the practitioners or hospitals who treated you to furnish the board any information it may request with respect to said treatment.*

G. Have you ever been dropped, suspended, or disciplined by any school or college for any cause whatsoever? ☐ Yes ☐ No

**If yes, state reasons fully on rider, giving name of school, dates, and cause.*

4. APPLICANT HISTORY—PROFESSIONAL LICENSURE

A. Have you ever been denied the right to take a dentistry examination in any state? ☐ Yes ☐ No

B. Have you ever been refused a license to practice dentistry or any other license—or the renewal thereof—in any state? ☐ Yes ☐ No

C. Have you ever had a license or certificate of registration to practice dentistry, or any other licensed profession revoked, suspended, or otherwise acted against (including probation, fine, or reprimand) in a disciplinary proceeding in any state? ☐ Yes ☐ No

D. Are you now or have you ever been a defendant in civil litigation in which the basis of the complaint against you was negligence, malpractice, or lack of professional competence? ☐ Yes ☐ No

E. Is there currently pending against you, in any jurisdiction, a complaint against your professional conduct or competence as a dentist? ☐ Yes ☐ No

**If any of the questions 4A through 4E above is answered yes, you must provide complete details as to state(s), license number(s), dates, and relevant circumstances in a rider.*

F. List below **all** dental clinical licensing examinations you have taken, and indicate your results. If you need additional space, please attach a rider. If you failed any portion of any dental examination, provide all relevant details in a rider.

NAME OF EXAM	DATE TAKEN	PASS/FAIL	PORTION FAILED

G. I am licensed to practice in the following jurisdictions and no others:

JURISDICTION	LICENSED BY (i.e. examination, credentials, etc.)	LICENSE NO. AND DATE ISSUED	YEARS OF PRACTICE	TYPE OF PRACTICE

H. If you have been admitted to practice in any jurisdiction, provide the following certification and make a complete statement of all your practices since graduation to date. Include temporary or part-time work.

PERIOD OF PRACTICE BEGAN—ENDED	NAME AND ADDRESS OF EMPLOYERS, ASSOCIATES, ETC.	REASON FOR LEAVING

I. NATIONAL BOARDS: Have you successfully completed the National Board Examination in dentistry? ☐ Yes ☐ No

**Results are obtained from the ADA (312-440-2676) and must be sent directly to the Louisiana State Board of Dentistry. If you have taken the national boards more than once, a full history should be provided if available from the ADA.*

J. Do you currently belong or have you ever belonged to a local, district, or state dental association? ☐ Yes ☐ No

If yes, give name of association and date you became a member: ____________________

Have you ever resigned or been dropped from the roll of any of these associations: ☐ Yes ☐ No

**If yes, give name of association, date, and explanation on a rider.*

K. Do you use a laser in your dental practice? ☐ Yes ☐ No

L. Do you possess a current certificate in the Cardiopulmonary Resuscitation Course "C" Basic Life Support for Healthcare Providers as defined by the American Heart Association, the American Red Cross Professional Rescue Course, or an equivalent? ☐ Yes ☐ No

**Please provide a copy of your certificate.*

5. OFFICIAL CERTIFICATIONS

A.

RECOMMENDATION BY STATE DENTAL ASSOCIATION
(If you are not a member of a state association, leave this portion blank.)

I, ________________________________, Executive Director of the ________________________________ Dental Association certify that _______________________________________ has been a member in good standing of said association for __________. I further certify to the reputability of said applicant as appears of record in this office, and it based upon this record that I am able to recommend him/her, on behalf of the association, to the Louisiana State Board of Dentistry as a fit and proper person to receive a license.

Date ________________________________ ________________________________

Signature of Executive Director
(Place seal here)

NOTE:
A "reputable record," for the purpose of this portion of the application, is one which reflects no unfavorable decisions in connection with peer review or any other breach of professional or ethical standards to which said association subscribes.
If the executive director is unable to recommend said applicant, the Louisiana State Board of Dentistry requests you forward all derogatory information in connection with applicant's association record directly to the board's office.

B.

CERTIFICATE OF DENTAL COLLEGE GRANTING DEGREE

I hereby certify that _______________________________________ matriculated in the ________________________________ Dental College located in ____________________________________ on the ________ day of ______________________, 20______, and attended and successfully completed a full course in professional dentistry comprised of four academic years of instruction. I further certify the above named applicant has graduated or will graduate with the degree of _______________________________________ on the ________ day of ______________________, 20______. Certification is also made that the photograph as appears in this application is the likeness of said applicant and is the identical person to whom the said diploma was originally issued.

Date ________________________________ ________________________________

Signature of Dean
(Place seal here)

C.

CERTIFICATE OF SECRETARY OF BOARD OF DENTAL EXAMINERS OF THE STATE IN WHICH APPLICANT IS CURRENTLY PRACTICING OR LAST STATE IN WHICH APPLICANT ATTAINED LICENSURE

I, _______________________________, Secretary of ____, hereby certify that ____ was granted state License No. _________________ to practice dentistry in the state of ___________________________ on the ________ day of ______________________, 20______.
Acting on behalf of the said board, I hereby certify to the reputability of said applicant as appears of record in this office and recommend him/her to the Louisiana State Board of Dentistry as a fit and proper person to receive a license. I also certify the photograph as appears in this application is the likeness of said applicant and the person named in the above endorsement.

Date ________________________________ ________________________________

Signature of Secretary
(Place seal here)

6. AFFIDAVIT

In addition to the foregoing, I add the following:

(a) I have read the Louisiana Dental Practice Act. I solemnly declare upon my honor that if granted a license to practice dentistry in Louisiana, I will respectively comply with any law governing the practice of dentistry in this state and will do my best to uphold and maintain the ethics of the profession.

(b) I hereby give permission to the Louisiana State Board of Dentistry to secure additional information concerning me or any statement in this application from any person or any source the Board may desire. 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 check or money order in the amount of $__________ made payable to the Louisiana State Board of Dentistry to cover the cost of the license. I understand that this fee is non-refundable.

(d) I hereby affirm that I have received a self-reporting form from the Louisiana State Board of Dentistry relative to the reporting of my serostatus of the human immunodeficiency virus, the hepatitis B virus, and the hepatitis C virus as required by Louisiana Administrative Code—Title 46 (Professional and Occupational Standards—Dental Health Professions) Chapter 12 "Transmission prevention of HIV/HBV/HCV."

(e) I, ____, the applicant herein, state and depose 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 serve as sufficient grounds for the suspension, cancellation, or revocation of my Louisiana dental license even if it is not discovered until after issuance.

____
Applicant's Signature

State of ___________________________________

Parish/County of ____________________________

Before me, the undersigned authority, on this day personally appeared _________________________________, who, after being duly sworn by me on his/her oath, certifies that all facts, statements, and answers contained in this application are true and correct in every respect, and that the attached photograph is a true likeness of the applicant.

____
Applicant-Affiant

Sworn to and subscribed to before me on this ________ day of ______________________, 20______, to certify which witness my hand and official seal of office.

____
Notary Public

SEAL

Parish/County of _________________________________ State of _________________________________

or State of ____ at Large.

MAKE ALL FEES PAYABLE TO THE LOUISIANA STATE BOARD OF DENTISTRY

RETURN TO
LOUISIANA STATE BOARD OF DENTISTRY
365 CANAL STREET
SUITE 2680
NEW ORLEANS, LOUISIANA 70130

AUTHORIZATION FOR THE RELEASE OF CONFIDENTIAL INFORMATION

PLEASE PRINT OR TYPE ALL INFORMATION REQUIRED

(COMPLETE ONLY IF YOU HAVE TESTED POSITIVE FOR HIV, HBV OR HCV)

I authorize ____ and the physicians
Name of Hospital/Physician/Facility

who treated ____ to release to
Name of Patient

Louisiana State Board of Dentistry
One Canal Place, Suite 2680
365 Canal Street
New Orleans, Louisiana 70130
(504) 568-8574

my medical record or specific information relative to:

TEST RESULTS FOR HUMAN IMMUNODEFICIENCY VIRUS, HEPATITIS B VIRUS OR HEPATITIS C VIRUS

I understand that the Louisiana State Board of Dentistry is mandated by R.S. 37:1747 to establish procedures for reporting a licensee's status as a carrier of HIV, HBV, or HCV, and that pursuant to Louisiana Administrative Code (Title 46 – Professional and Occupational Standards – Part XXXIII Dental Health Professions:) Chapter 12, § 1207, I am required by law to report my seropositive status or be subjected to those sanctions associated with violations of R.S. 37:776.

I further understand that the release of reports called for herein shall be maintained in confidence as required by Louisiana Administrative Code (Title 46 – Professional and Occupational Standards – Part XXXIII Dental Health Professions:) Chapter 12, § 1208.

Signed ______________________
Patient

____
Patient's date of birth

____
Date of Signature

____
Patient's Social Security Number

In Patient ______________________
Date(s)

Emergency Room ______________________
Date

Outpatient ____
Date(s)/Type of Service

§1747. Hepatitis B or Human Immunodeficiency carriers; practice requirements; report procedures; exemptions

A. Each board licensing health care providers shall establish by rule practice requirements based on applicable guidelines from the Federal Centers for Disease Control which will protect the public from the transmission of the hepatitis B virus or human immunodeficiency virus in the practice of a profession regulated by the appropriate board.

B. The boards shall by rule, based on applicable guidelines from the Federal Centers for Disease Control, establish requirements and procedures for a licensee and a licensure applicant to report his status as a carrier of the hepatitis B virus or human immunodeficiency virus to the board and shall enforce such requirements and procedures.

C. Each report of hepatitis B virus carrier status or human immunodeficiency virus carrier status filed by a licensee or licensure applicant in compliance with this section and each record maintained and meeting held by the boards in the course of monitoring a licensee for compliance with the practice requirements established by Subsection A are confidential and exempt from the public records by R.S. 44:4(7), (9), and (11), except for the purpose of the investigation or prosecution of alleged violations of this part by the boards.

§1207 Self-Reporting

A. Any dental health care provider who in the course of practice may at any time undertake to perform or participate in an exposure-prone procedure and who is or becomes HBV seropositive, HCV seropositive, or HIV seropositive shall be required to give notice of such seropositivity to the board in accordance with the provisions of this Section.

B. Within 90 days of the effective date of this Chapter, any dental health care provider who has previously been verified as being HBV seropositive, HCV seropositive, or HIV seropositive shall give notice of such diagnosis to the board on a reporting form supplied by the board.

C. Within 10 days from the date on which a dental health care provider has been verified as being HBV seropositive, HCV seropositive, or HIV seropositive, the dental health care provider shall give notice of such diagnosis to the board on a reporting form supplied by the board which shall be mailed to the executive director of the board, marked "Personal and Confidential" by registered or certified mail.

D. An applicant for licensure as a dental health care provider who at the time of application is verified as being HBV seropositive, HCV seropositive, or HIV seropositive shall acknowledge such diagnosis in his or her written application to the board.

E. Aforementioned reporting forms will be provided to each licensee with his or her license and additionally with his or her biennial renewal application, or upon request.

F. The seropositive dental health care provider must submit to evaluation within 15 working days of his notification by the board ordering said dental health care provider to be examined by experts selected by the board, and those experts must complete and submit their reports to the executive director of the board within 15 days following their examination.

G. Reports from two physicians and two laboratories evidencing change in the dental health care provider's serostatus shall be submitted to the executive director for board evaluation of the change of the serostatus when any dental health care provider previously verified as HBV seropositive or HCV seropositive who becomes HBV seronegative or HCV seronegative.

H. Any dental health care provider or applicant for licensure who is required under this Section to report his/her HBV, HCV, or HIV seropositive status and fails or neglects to provide notice as set forth in this Section shall be deemed in violation of R.S. 37:776(A)(1), (3), (7), (12), (16), (17), (20) and (24), and subject to sanctions associated therewith.

§1208. Confidentiality of Reported Information

A. Reports and information furnished to the board pursuant to §1207 of this Chapter and records of the board relative to such information shall not be deemed public records, but shall be deemed and maintained by the board as confidential and privileged and shall not be subject to disclosure by means of subpoena in any judicial, administrative or investigative proceeding; provided that such reports, information and records may be disclosed by the board as necessary for the board to investigate or prosecute alleged violations of this Chapter.

B. The identity of the seropositive practitioner or applicant for licensure who has reported their status as being HBV, HCV, or HIV seropositive pursuant to §1207 of this Chapter shall be maintained in confidence by the board on all matters pertaining to the HBV, HCV, and HIV diseases, and shall not be disclosed to any other party, except as may be necessary in the investigation or prosecution of suspected violations of this Chapter, necessary for the evaluation and monitoring of the physical and psychological condition of the seropositive practitioner or applicant for licensure, or as allowed by R.S. 40:1300.14.

C. Provided that the identity of self-reporting practitioners and applicants seeking licensure is not disclosed, the provisions of this Section shall not be deemed to prevent disclosure by the board of statistical data derived from such reports, including, without limitation, the number and licensure class of those who have reported themselves as HBV, HCV, or HIV seropositive and their geographical distribution.