

**LOUISIANA STATE BOARD OF DENTISTRY
ONE CANAL PLACE, SUITE 2680
365 CANAL STREET
NEW ORLEANS, LOUISIANA 70130
TELEPHONE NO. (504) 568-8574
FAX NO. (504) 568-8598**

NAME _____ DATE _____

DENTAL LICENSURE BY EXAMINATION IN ANOTHER JURISDICTION

CHECKLIST (Please use this as a checklist to assure you have attached all required information)

PLEASE CONTACT THE BOARD OFFICE DIRECTLY FOR FINGERPRINT CARDS AS THEY CANNOT BE DOWNLOADED FROM OUR WEBSITE.

******PROCESSING OF APPLICATIONS WILL TAKE A MINIMUM OF EIGHT TO TWELVE WEEKS FROM DATE OF RECEIPT IN OUR OFFICE. WE WILL PROCESS YOUR APPLICATION AS SOON AS WE POSSIBLY CAN. LICENSES WILL NOT BE ISSUED UNTIL APPLICATION IS COMPLETE INCLUDING RESULTS OF BACKGROUND CHECK. PLEASE DO NOT CALL OUR OFFICE FOR A "RUSH REQUEST" AS IT IS IMPOSSIBLE.******

- 1. Enclosed original or certified true copy of birth certificate or other documentation of U.S. citizenship or permanent resident status or eligible status under the North American Free Trade Agreement (NAFTA)
- 2. Included non-refundable application fee of \$400.00
- 3. Have sent application to proper entities for certifications/seals, including proof of graduation date of _____ from an accredited dental school
- 4. Have fully completed required application form with all supporting data and certification of competency and good character
- 5. Have submitted a recent passport type photograph
- 6. Have provided true copy of national board examination grades
- 7. Have requested true copy of proof of successful completion of dental examination including procedures on a live patient to be sent from the appropriate testing agency directly to the Louisiana State Board of Dentistry
- 8. If ever licensed in another state, provide certification of licensure from appropriate state board(s)
- 9. Possess a current certificate in CPR Course "C," Basic Life Support for Health Care Providers as defined by the American Heart Association, the American Red Cross Professional Rescue Course, or their equivalent. Attach a copy of the certificate to the application
- 10. Submitted all required fingerprint information
 - cards
 - sheets
 - to Camp _____
 - complete
- 11. Called board office at number above to arrange to take jurisprudence examination

PHOTOGRAPH OF APPLICANT

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.)



FOR OFFICE USE ONLY

Fee Paid _____
 National Board Scores _____
 CPR: _____
 Photograph _____
 Proof of Citizenship: _____
 Fingerprints _____
 License Number Issued _____
 Date Issued _____
 Jurisprudence _____

LOUISIANA STATE BOARD OF DENTISTRY
APPLICATION FOR DENTAL LICENSE
BY EXAMINATION IN ANOTHER JURISDICTION

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, with your signature, specifying the number of the question to which it relates and enclose it with this application. You must attach to this application an original or certified true copy of documentation evidencing your citizenship or permanent resident status or eligibility under the North American Free Trade Agreement. You must also include a current autographed (on the back) passport size photograph and proof of current cardiopulmonary resuscitation (CPR) certification.

1. APPLICANT PROFILE DATA

A. NAME	Last _____	First _____	Middle _____
B. SOCIAL SECURITY NUMBER	_____		
C. MAILING ADDRESS	Street and Number _____	Apt. No. _____	City, State ZIP _____
D. RESIDENCE ADDRESS	Street and Number _____	Apt. No. _____	City, State ZIP _____
E. TELEPHONE NUMBERS	Home: _____	Business: _____	F. CITIZEN OR PERMANENT RESIDENT OF U.S. <input type="checkbox"/> Yes <input type="checkbox"/> No
G. OTHER NAMES	Have you ever changed your name through marriage or through action of the court, or have you ever been known by any other name? <input type="checkbox"/> Yes <input type="checkbox"/> No. If yes, list name(s), and reason for change below. If by court order, enclose herein a certified copy of such order. _____ _____		
H.	DATE OF BIRTH _____ AGE: _____ PLACE OF BIRTH _____		
I.	SEX _____ HEIGHT _____ WEIGHT _____ RACE _____ BUILD _____ EYE COLOR _____ HAIR COLOR _____ COMPLEXION _____ IDENTIFYING MARKS _____		
J.	MARITAL STATUS: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		
K. SPOUSE	If married, give spouse's full name: _____ (If woman, give maiden name)		
L. FATHER	Full Name _____	Street and Number _____	City, State ZIP _____
M. 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
1 st Year _____	_____
2 nd Year _____	_____
3 rd Year _____	_____
4 th 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
1 st Year _____	_____
2 nd Year _____	_____
3 rd Year _____	_____
4 th Year _____	_____

C. **POST GRADUATE EDUCATION**

Name and Location of Institution	Period of Attendance
1 st Year _____	_____
2 nd Year _____	_____
3 rd 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? Yes No
(Do not include parking or speeding violations.)

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

F. Have you ever failed the dental examinations given by another board or testing agency? Yes No
If yes, how many times? _____

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

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

JURISDICTION	LICENSED BY (i.e. examination, credentials, etc.)	LICENSE NO.	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 must be attached to your completed application. Results are obtained directly from the National Board of Dental Examiners at 211 East Chicago Avenue, Chicago, Illinois 60611. Phone: 312-440-2676. If you have taken the National Boards more than once, a full history should be provided if available from the National Board's office.*

J. Are you 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 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 _____

(Place seal here)

Signature of Dean

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 application and the person named in the above endorsement.

Date _____

(Place seal here)

Signature of Secretary

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
ONE CANAL PLACE
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 _____	Emergency Room _____
Date(s)	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.