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 ______
Photograph ______
License Number Issued ______
Date Issued ______
Jurisprudence ______

APPLICATION FOR RESTRICTED LICENSE

Application Fee (Non-Refundable) $100.00

Instructions for the applicant:

Print legibly or use a typewriter to provide the following information. If the space for any answer is insufficient, the applicant must complete his/her answer on a rider, signed by him/her, specifying the number of the question to which it relates and enclose it with this application. You must include one current autographed (on the back) passport size photograph.

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. ☐ Yes ☐ 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? ☐ Yes ☐ 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: ☐ Single ☐ Married ☐ Divorced ☐ 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
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
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. 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 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

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 application and the person named in the above endorsement.

Date ____ ____

(Place seal here) *Signature of Secretary*

6. CERTIFYING AUTHORITY DATA

A. Name and address of certifying authority: ______________________________

____

B. Give job title: ______________________________
(use official title)

C. Give a brief, but complete, description of your duties in connection with your employment.

____

____

____

D. **CERTIFICATION OF DENTAL COLLEGE EMPLOYING APPLICANT**

I, ______________________________, Dean of the College of Dentistry at ______________________________ certify to the reputability of ______________________________, who is applying for a Restricted Dental License. I further certify that ______________________________ is registered and/or employed as ______________________________ (job title) with the aforementioned college or university, and his/her duties are restricted to practicing his/her profession only in connection with the terms of his/her employment at said dental college or university. In the event the employment of said dentist is terminated, the certifying authority will notify the Louisiana State Board of Dentistry in writing within ten (10) days.

Date ______________________________ ______________________________
Signature of Dean

(Place seal here)

E. **CERTIFICATION OF HOSPITAL, STATE INSTITUTION, OR STATE AGENCY EMPLOYING APPLICANT**

I, ______________________________, Director of the ______________________________ certify to the reputability of ______________________________, who is applying for a Restricted Dental License. I further certify that ______________________________ is registered and/or employed as ______________________________ (job title) with the ______________________________, and his/her duties are restricted to practicing his/her profession only in connection with the terms of his/her employment with the aforementioned institution. In the event the employment of said dentist is terminated, the certifying authority will notify the Louisiana State Board of Dentistry in writing within ten (10) days.

Date ______________________________ ______________________________
Signature of Director

(Place seal here)

7. 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 Louisiana Restricted Dental License I will respectively comply with any law governing the practice of dentistry in this state and will confine the practice of my profession in accordance with L.R.S. 37:760 (12) which states in part: “All holders of restrictive licenses shall practice their profession only in connection with the terms of their employment. Additionally, I 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 $100.00 made payable to the Louisiana State Board of Dentistry to cover the fee for the Restricted Dental License. I understand that this fee will be returned only if this application is not accepted by the Board.

(d) I understand that if granted a Louisiana Restricted Dental License, same must be reapplied for annually. I further understand failure to re-apply for said license each year may result in the suspension or revocation of my Restricted Dental License. I acknowledge it is my responsibility by law, along with the certifying authority’s, to notify the Secretary-Treasurer of the Louisiana State Board of Dentistry should for any reason my employment be terminated with the certifying authority. This notice must be submitted in writing within ten (10) days of said termination.

(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 be sufficient to bar me from receiving a Restricted license or any other license issued by the Louisiana State Board of Dentistry, and any such falsifications, omissions, or withholding shall serve as sufficient grounds for the suspension, cancellation, or revocation of my Restricted 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