Louisiana State Board of Dentistry
P.O. Box 5256
Baton Rouge, Louisiana 70821-5256
225.219.7330 Telephone ~ 225.219.0707 Fax
www.lsbd.org

APPLICATION FOR DENTAL LICENSE BY CREDENTIALS

NON-REFUNDABLE APPLICATION FEE $2100
DENTAL HEALTH CARE PRACTITIONER WELL BEING PROGRAM FEE $50

ALL APPLICATIONS MUST BE MAILED TO THE BOARD OFFICE. DO NOT BRING THEM IN PERSON. IF YOU PREFER TO FEDEX YOUR APPLICATION, PLEASE CALL THE BOARD OFFICE FOR THE PHYSICAL ADDRESS.

REQUIREMENTS FOR LICENSURE

Each applicant applying for a Louisiana dental license by credentials must complete each of the following.

1. Have graduated from a dental school that was accredited at the time of the applicant's graduation by the Commission on Dental Accreditation of the American Dental Association.
2. Have successfully completed a clinical licensing examination which included procedures on live subjects at some point in the licensure history. The applicant may not have failed any clinical examination more than twice. (If you have failed three times or more, contact the Board office directly.)
3. Have successfully completed the National Board Dental Examination.
4. Possess a current certificate in cardiopulmonary resuscitation basic life support for healthcare providers
5. Be a United States citizen or permanent resident or be legally authorized to reside and work in the U.S.
6. Successfully complete the Louisiana State Board of Dentistry jurisprudence examination
7. Submit to a fingerprint background check
8. Complete and submit the entire notarized dental license by credentials application
9. Possess a nonrestricted dental license in another state
10. Demonstrate appropriate practice history by one of the following:
    a. Have practiced dentistry (or worked full time in dental education as a teacher) for at least 1000 hours per year for each of the three years immediately preceding the Louisiana LBC application; OR
    b. Have completed a residency in a Board recognized specialty or two year GPR and apply for licensure within 180 days of the completion of the residency.
11. Provide three reference letters from dental professionals unrelated to the applicant. Letters should not be from previous instructors.
12. Provide any DEA certificate number and controlled substances licenses ever held.
13. Provide license certifications from each jurisdiction where a license has ever been held.
14. Provide the sealed results of a self-query from the NPDB.
15. Explain any malpractice payments.
16. Provide affidavits showing that professional liability insurance has never been revoked, modified, or non-renewed and that there are no unresolved complaints against the licensee.
17. Have completed continuing education as required by the state(s) of current licensure.
18. Complete an acceptable opioid management course and submit the completion certificate along with the application. *(New as of 1/1/2019, see details below)*
19. Pay all applicable fees

GENERAL INFORMATION

- Read all information and instructions prior to completing and submitting your application.
- *The board is unable to "rush" applications*. The standard processing time is approximately 30 days **after** receipt of your **completed application**. This includes all attachments and documents sent on your behalf by a third party.
- You should not make commitments on loans, practice start dates, home purchases, etc., until a license has been granted and you have it in your possession.
- The board will not verify receipt of third party documents prior to receipt of a completed application.
- Applicants should manage their own applications. The board will not communicate with any third party regarding the status of an application.

It is at the sole discretion of this board to grant licensure, and the filing of this application, along with the $2100 fee, in no way guarantees approval of licensure.

*****NOTE*****

Effective January 1, 2019, all applicants for a dental license must complete an opioid management course and submit the course completion certificate with their completed application. This is required by Act 76 of the 2017 legislative session. Please see below for additional information.

PROOF OF U.S. CITIZENSHIP OR PERMANENT RESIDENCY STATUS OR LEGAL AUTHORITY TO LIVE AND WORK IN THE U.S.

You must show documentation that you have current, valid authority to live and work in the United States. All documentation must be an original or certified true copy and mailed to the board office. **Documents you send to the Louisiana State Board of Dentistry will <u>not</u> be returned to you.**

U.S. citizens must submit an original or certified true copy of your

- U.S. birth certificate (available from the vital statistics office in the U.S. state in which you were born), or
- U.S. naturalization certificate.

U.S. permanent residents must submit an original or certified true copy of your current U.S. permanent resident card.

If you are NOT a U.S. citizen or permanent resident, please call the Board office directly to determine what documentation you should submit.

FEES

The **non-refundable** application fee is $2100. There is an additional **mandatory** $50 fee to fund the Dental Health Care Practitioner Well-Being Program. The board accepts only checks or money orders. Checks and money orders must be made payable to the Louisiana State Board of Dentistry.

FINGERPRINT BACKGROUND CHECK

All applicants for a Louisiana dental license must submit to a fingerprint background check. You must contact the board office directly to request a set of forms and 2 fingerprint cards be mailed to you. Once you receive the cards and forms from the board office, you have two options for submitting your fingerprints for the background check:

1. You may take the cards and forms to a local law enforcement agency to have your fingerprints taken. You will then mail all forms and both fingerprint cards directly to the board office. The board will then in turn submit your fingerprints to the Louisiana State Police for review. *The $2100 application fee includes the board's costs for the background check; therefore, the board will* ***not*** *submit your prints to the LSP unless and until your application and fee have been received.* The LSP will contact the board directly with the results of your background check. It may take up to 16 weeks for a response from the LSP.
2. You may take your fingerprint cards and forms directly to the Louisiana State Police headquarters located at 7919 Independence Boulevard, Baton Rouge, Louisiana 70806. You will pay the LSP a separate fee for this service. The LSP then sends the results of the check directly to the board office. It generally takes 2 to 3 weeks for a response from the LSP.

OPIOID MANAGEMENT COURSE

Effective January 1, 2019, all applicants must complete 3 hours of opioid management to receive their Louisiana dental license. This is required by the Louisiana Legislature to renew your license in the future. This is a one time requirement and you may use it to satisfy your opioid management CE requirement for your first license renewal. The board maintains a list of approved opioid management CE courses on the CE page of its website at http://www.lsbd.org/conted.htm. The first course listed is offered through Dentalcare.com and will satisfy the requirement entirely. *There is no cost for the Dentalcare.com online course listed.*

JURISPRUDENCE EXAMINATION

All applicants for a dental license must complete the jurisprudence examination. The test consists of 100 true/false and multiple choice questions. You must answer 75 correctly to pass the exam. The information you will be tested on may be found in the Louisiana Dental Practice Act. You may download and print a copy of the DPA from the Board's website at www.lsbd.org.

Please contact the Board office to schedule the jurisprudence exam. **You may not schedule your jurisprudence test unless and until your application and fees have been received in the board office.**

Jurisprudence test scores are valid for one year. If your license is to be issued more than one year after you complete the jurisprudence exam, you must retake it.

APPLICATION TIMELINE

The Board office will notify you of any deficiencies in your application. Repeatedly calling the board hinders the processing of your application.

The processing of licensure applications will take approximately 30 days after the Board's receipt of your **completed** application. This includes ALL fees, application, background check results, documentation, and jurisprudence test. Plan your application time accordingly. Rush requests are not possible.

RELOCATION

If your address changes after you submit your application and before you receive your license, you **must** notify the Board of your new address. This notification must be in writing and either faxed, emailed, or mailed to the Board office. The Board is not responsible for licenses sent to an incorrect address due to an applicant's failure to update his or her address with the Board.

DOCUMENTATION TO BE SUBMITTED WITH YOUR APPLICATION

Please use the following checklists to ensure your application is complete prior to your submitting it to the board office.

ALL APPLICANTS MUST SUBMIT THE FOLLOWING ITEMS WITH THEIR APPLICATION TO THE BOARD OFFICE:

- ☐ 1. Recent, passport sized color photograph with name written and signed on the back
- ☐ 2. Original or certified true copy of U.S. birth or naturalization certificate or proof of your legal authorization to live and work in the U.S. Certified true copies of your U.S. birth certificate are obtained from the vital statistics office in the state in which you were born. Photocopies of the applicant's copy will not be accepted. **Any documents you send to the Louisiana State Board of Dentistry will not be returned.**
- ☐ 3. Copy of your current CPR card. The courses accepted are the American Heart Association's Healthcare Provider and the American Red Cross Professional Rescue course, or their equivalent. CPR courses which are completed entirely online are not acceptable. Please contact the Board office to determine whether your course is acceptable.
- ☐ 4. Completed fingerprint cards and forms (unless you have taken the blank cards and forms directly to the Louisiana State Police)
- ☐ 5. Completed, notarized application
- ☐ 6. Completion certificate from your opioid management course
- ☐ 7. Completed, notarized affidavit regarding your liability insurance and unresolved complaints
- ☐ 8. Completed physician's statement
- ☐ 9. A copy of your current DEA certificate and any controlled substances licenses
- ☐ 10. CE certificates from within the past 2 years which show your compliance with your state's CE requirements.
- ☐ 11. One check or money order made out to the Louisiana State Board of Dentistry for the $2100 application fee
- ☐ 12. One check or money order made out to the Louisiana State Board of Dentistry for the $50 well-being program fee

ADDITIONAL ATTACHMENTS AS REQUIRED

- ☐ 1. If you have tested seropositive for HIV, HBV, or HCV, you must include the self-reporting form (page 7). **COMPLETE THIS FORM ONLY IF YOU HAVE TESTED SEROPOSITIVE FOR HIV, HBV, OR HCV.**
- ☐ 2. If you have served in the U.S. military and are separated, attach a copy of your DD-214.
- ☐ 3. Riders explaining details and circumstances for a specific question and any supporting documentation.

DOCUMENTATION TO BE SENT ON YOUR BEHALF DIRECTLY TO THE LOUISIANA STATE BOARD OF DENTISTRY BY A THIRD PARTY

To expedite your application, please have these entities send this information **after** the receipt of your application in the Board office.

☐ 1. An **official transcript** from your dental school along with any residencies or other training beyond dental school. Transcripts must be sent directly to the Board office and contain the graduation date and the degree received. Electronic transcripts are accepted and should be sent to alexx@lsbd.org.

☐ 2. National Board results. Contact the ADA to have your results released to the Louisiana State Board of Dentistry. Do **not** send the candidate's copy of the score report.

☐ 3. Proof of your successful completion of a clinical licensure examination which included procedures on a live patient. This is usually a score report from your testing agency.

☐ 4. If you completed dental school more than six months prior to your application for a Louisiana dental license, you must obtain a certification from each regional clinical testing agency indicating your exam history with that agency, regardless of your history with that agency. If you have not taken a clinical examination with the agency, this certification should contain a statement indicating that you have never attempted an examination with that agency.

☐ 5. A certification of your license from each board of dentistry where you hold or have ever held a license. You may use the form included, or you may have each board send a certification letter as long as it contains the requested information. *Do not have certifications sent to the Louisiana State Board of Dentistry until **after** your application has been received in the Board office. We cannot file certifications appropriately unless there is an application with which to associate them.*

☐ 6. National Practitioner Data Bank (NPDB) self-query. Please visit www.npdb.hrsa.gov to request a self-query. *The results must remain in the original sealed envelope and be attached to your application to the Board.*

☐ 7. Have ***three*** dentists submit letters of recommendation regarding your practice of dentistry. If they prefer to use affidavits, they may use the included form.

☐ 8. Have your malpractice insurance carriers submit documentation of your claims history for the past **ten years**.

ADDITIONAL REQUIREMENTS

☐ 1. Once your application has been received, contact the Board office directly to schedule your jurisprudence examination.

INSTRUCTIONS FOR THE APPLICANT

Print legibly or use a typewriter to complete the application.

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 space to answer any question(s), complete your answer on an additional sheet of paper and attach it to your application.

You must include a recent, color, passport sized photograph with your application. Write and sign your name on the back of the photograph, then attach it to your application in the space provided on the first page.

A. PERSONAL INFORMATION

Give the personal information requested.

Question 6: Any board correspondence will be sent to your mailing address, **including your original license.**

B. EDUCATION INFORMATION

Give the education information requested.

Question 20: If your dental education was interrupted or lasted longer than the standard 4 years, you must provide all details in a rider.

C. GENERAL HISTORY

Any "yes" responses in this section **must** be accompanied by a rider attached to your application. In the rider specify the question number and section to which you are responding. Give all relevant dates, circumstances, dispositions, outcomes, etc. Include copies of any documentation.

Failure to include a detailed explanation **will** result in a processing delay.

Question 27: Even if you believe an arrest or conviction or other incident was expunged, it **must** be disclosed to the board. As a healthcare profession licensing agency, the board **will** receive all criminal record information *including expunged records.* Material omissions are considered grounds for license denial.

D. PROFESSIONAL HISTORY

Any "yes" responses in this section **must** be accompanied by a rider attached to your application. In the rider specify the question number and section to which you are responding. Give all relevant dates, circumstances, dispositions, outcomes, etc. Include copies of any documentation.

Failure to include a detailed explanation **will** result in a processing delay.

E. AFFIDAVIT

You must complete this section and sign it in front of a notary. Applications which are not notarized will be returned to the applicant.

LOUISIANA STATE BOARD OF DENTISTRY
DENTAL LICENSE BY CREDENTIALS APPLICATION

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 attached to this space and must not be larger than space provided. (No hats or caps, please.)	Application fee _____ PHF fee _____ National board scores _____ CPR _____ Photograph _____ Proof of citizenship _____ Fingerprints sent _____ Fingerprints received _____	Jurisprudence _____ Transcript _____ Regional exam _____ Opioid management _____ Other state certifications _____ NPDB-HIPDB _____ License number issued _____ Date Issued _____

A. PERSONAL INFORMATION

1. Name: _____
   First Middle Last
2. Name as you wish it to appear on your board license: _____
3. List all previous names and reason(s) for change. If by court order, enclose a copy of such order.
   _____
   _____
4. Social security number: _____
5. Citizen or permanent resident of the U.S. OR do you possess valid and current legal authority to live and work in the U.S.? ☐ Yes ☐ No
6. Current mailing address:
   _____
   Number and street City State ZIP
7. Current home address:
   _____
   Number and street City State ZIP
8. Home phone: _____ Cell phone: _____
9. Email address: _____ Use this email address for board correspondence? ☐ Yes ☐ No
10. Place of birth: _____ Date of birth: _____ Age: _____
11. Sex: _____ Height: _____ Weight: _____ Race: _____
12. Eye color: _____ Hair color: _____
13. Identifying marks: _____
14. Clinical licensing examination: _____ Date completed: _____
15. Marital status:
    ☐ Single ☐ Married ☐ Divorced ☐ Widowed
16. Spouse's full name (include original last name): _____
17. Father's full name and current address:
    _____
    Full name Number and street City, state ZIP
18. Mother's full name and current address:
    _____
    Full name Number and street City, state ZIP

B. EDUCATION INFORMATION

19. **UNDERGRADUATE EDUCATION (AS SEPARATE FROM 4 YEAR DENTAL EDUCATION)**

College/university attended	Location	From month/year	To month/year

Degree received: _____ Date degree received: _____

20. **DENTAL EDUCATION**

Dental school attended	Location	Number of years	From month/year	To month/year

Degree received: _____ Date degree received: _____

Was your dental education interrupted (other than for the usual vacation periods) or extended beyond the standard four years? If so, explain the circumstances in a rider. ☐ Yes ☐ No

21. **POST-GRADUATE DENTAL EDUCATION**

Dental school attended	Location	Number of years	From month/year	To month/year

Certificate received: _____ Date certificate received: _____

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

If yes, give branch: _____

Do you plan to practice as a specialist in Louisiana? ☐ Yes ☐ No

If yes, give branch: _____

23. Are you a diplomate of a specialty board? ☐ Yes ☐ No

If yes, give name of specialty board and date of certification: _____

24. 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? (Attach copy of CPR card.) ☐ Yes ☐ No

25. Have you successfully completed Parts I and II of the National Board Dental Examination? ☐ Yes ☐ No
(Results must be sent directly to the board office from the ADA.)

C. GENERAL HISTORY

ANY "YES" ANSWERS IN THE FOLLOWING SECTION **MUST** BE EXPLAINED IN DETAIL IN A RIDER ATTACHED TO YOUR APPLICATION.

26. Provide a chronological history of your **home address for the past seven years**. There can be no time gaps.
If you need additional space, attach another sheet to this application.

Home address:

_____
Number and street City State ZIP

Start date: _____ End date: _____

Home address:

_____
Number and street City State ZIP

Start date: _____ End date: _____

Home address:

_____
Number and street City State ZIP

Start date: _____ End date: _____

27. Have you ever been summoned, arrested, taken into custody, indicted, convicted or tried for, or charged with, or pled guilty to, or pled nolo contendere to a violation of any law or ordinance or the commission of any felony or misdemeanor (excluding minor traffic violations—*DUI and DWI are **not** minor traffic violations*), or have you been requested to appear before a prosecuting attorney or investigative agency in any matter? ☐ Yes ☐ No
Although a conviction may have been expunged from the records by order of court, it nevertheless must be disclosed in your answer to this question. If you entered and completed a pretrial intervention program or diversion program, all details must be disclosed.
A "YES" ANSWER **MUST** BE EXPLAINED IN DETAIL IN A RIDER. LIST RELEVANT DETAILS, DATES, CIRCUMSTANCES AND DISPOSITION.

28. 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
A "YES" ANSWER **MUST** BE EXPLAINED IN DETAIL IN A RIDER. LIST RELEVANT DETAILS, DATES, CIRCUMSTANCES AND DISPOSITION.

29. Branch of armed forces served in: _____ Date separated*: _____
*If separated, attached a copy of discharge
Have you ever been a defendant in a military court martial or received any discharge other than honorable? ☐ Yes ☐ No
A "YES" ANSWER **MUST** BE EXPLAINED IN DETAIL IN A RIDER. LIST RELEVANT DETAILS, DATES, CIRCUMSTANCES AND DISPOSITION.

30. Have you ever been dropped, suspended, or been the subject of any disciplinary action by any school or college for any cause whatsoever? ☐ Yes ☐ No
A "YES" ANSWER **MUST** BE EXPLAINED IN DETAIL IN A RIDER. INCLUDE DATES, DETAILS, AND CIRCUMSTANCES.

Questions 31 through 34 pertain to certain mental or physical conditions with which you may have been diagnosed. No mental or physical diagnosis in and of itself is an impediment to licensure. The Louisiana State Board of Dentistry focuses on the applicant's conduct and abilities to determine whether or not an applicant can practice safely. If you respond "yes" to any of the following 4 questions, you must attach an explanation in a rider. Depending on the explanation, the board may request your medical records.

31. Have you ever been declared legally incompetent? ☐ Yes ☐ No
A "YES" ANSWER **MUST** BE EXPLAINED IN DETAIL IN A RIDER. INCLUDE DATES, DETAILS, AND CIRCUMSTANCES.

32. Have you, in the last 5 years, engaged in any conduct deleterious to others which caused or required you to seek treatment for amnesia, emotional disturbances, or a mental disorder? ☐ Yes ☐ No
A "YES" ANSWER **MUST** BE EXPLAINED IN DETAIL IN A RIDER. INCLUDE DATES, DETAILS, AND CIRCUMSTANCES.

33. Have you been addicted to or received treatment for the use of drugs, narcotics, or intoxicating liquors within the past 5 years? ☐ Yes ☐ No
A "YES" ANSWER **MUST** BE EXPLAINED IN DETAIL IN A RIDER. INCLUDE DATES, DETAILS, AND CIRCUMSTANCES.

34. Do you have any physical or mental condition which currently affects or limits your ability to practice a full range of dentistry in other than a competent manner? ☐ Yes ☐ No
A "YES" ANSWER **MUST** BE EXPLAINED IN DETAIL IN A RIDER. INCLUDE DATES, DETAILS, AND CIRCUMSTANCES.

D. PROFESSIONAL INFORMATION

ANY "YES" ANSWERS IN THE FOLLOWING SECTION **MUST** BE EXPLAINED IN DETAIL IN A RIDER ATTACHED TO YOUR APPLICATION.

35. Provide a chronological history of your **professional employment from the date of your graduation from dental school**. There can be no time gaps. Indicate the address(es) of your current employment location(s). For periods of unemployment, check the box marked "unemployed" and provide the remaining information.
If you need additional space, attach another sheet to this application.

Employment information ☐ Current employment ☐ Unemployed

Start date: _____ End date: _____ Average hours worked per week: _____

_____
Number and street City State ZIP

Employment information ☐ Current employment ☐ Unemployed

Start date: _____ End date: _____ Average hours worked per week: _____

_____
Number and street City State ZIP

Employment information ☐ Current employment ☐ Unemployed

Start date: _____ End date: _____ Average hours worked per week: _____

_____
Number and street City State ZIP

Employment information ☐ Current employment ☐ Unemployed

Start date: _____ End date: _____ Average hours worked per week: _____

_____
Number and street City State ZIP

Employment information ☐ Current employment ☐ Unemployed

Start date: _____ End date: _____ Average hours worked per week: _____

_____
Number and street City State ZIP

Employment information ☐ Current employment ☐ Unemployed

Start date: _____ End date: _____ Average hours worked per week: _____

_____
Number and street City State ZIP

36. Why are you applying for a license in Louisiana?

_____

_____

37. Are there any unsatisfied judgements against you? ☐ Yes ☐ No
A "YES" ANSWER **MUST** BE EXPLAINED IN DETAIL IN A RIDER. INCLUDE DATES, DETAILS, AND CIRCUMSTANCES.

38. Have you ever been denied the right to take a clinical examination in any state? ☐ Yes ☐ No
A "YES" ANSWER **MUST** BE EXPLAINED IN DETAIL IN A RIDER. INCLUDE DATES, DETAILS, AND CIRCUMSTANCES.

39. Have you ever been refused a license to practice dentistry or any other license—or the renewal thereof—in any state? ☐ Yes ☐ No
A "YES" ANSWER **MUST** BE EXPLAINED IN DETAIL IN A RIDER. INCLUDE DATES, DETAILS, AND CIRCUMSTANCES.

40. 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 jurisdiction? ☐ Yes ☐ No
A "YES" ANSWER **MUST** BE EXPLAINED IN DETAIL IN A RIDER. INCLUDE DATES, DETAILS, AND CIRCUMSTANCES.

41. Is there currently pending against you, in any jurisdiction, a complaint against your professional conduct or competence as a dentist? ☐ Yes ☐ No
A "YES" ANSWER **MUST** BE EXPLAINED IN DETAIL IN A RIDER. INCLUDE DATES, DETAILS, AND CIRCUMSTANCES.

42. Have you ever been terminated from any dental or medical residency or internship program? ☐ Yes ☐ No
A "YES" ANSWER **MUST** BE EXPLAINED IN DETAIL IN A RIDER. INCLUDE DATES, DETAILS, AND CIRCUMSTANCES.

43. 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
A "YES" ANSWER **MUST** BE EXPLAINED IN DETAIL IN A RIDER. INCLUDE DATES, DETAILS, AND CIRCUMSTANCES.

44. Have you ever been refused any privilege of prescribing controlled substances, or had any prescribing privileges of controlled substances suspended or revoked? ☐ Yes ☐ No
A "YES" ANSWER **MUST** BE EXPLAINED IN DETAIL IN A RIDER. INCLUDE DATES, DETAILS, AND CIRCUMSTANCES.

45. Have you ever failed any clinical licensing examination? ☐ Yes ☐ No
A "YES" ANSWER **MUST** BE EXPLAINED IN DETAIL IN A RIDER. INCLUDE DATES, DETAILS, AND CIRCUMSTANCES.

46. List below **all** dental clinical licensing examinations you have taken and indicate your results. **Each attempt should be indicated as a separate entry.** If you need additional space, 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(s) failed*

IF YOU COMPLETED DENTAL SCHOOL MORE THAN 6 MONTHS PRIOR TO THE DATE YOUR APPLICATION AND ALL ATTACHMENTS ARE RECEIVED IN THE BOARD OFFICE, YOU MUST HAVE EVERY REGIONAL TESTING AGENCY SEND A CERTIFICATION OF YOUR EXAM HISTORY TO THE BOARD OFFICE. THIS MUST BE SENT EVEN IF YOU HAVE NEVER ATTEMPTED AN EXAMINATION WITH THE AGENCY. SEE INSTRUCTIONS FOR MORE INFORMATION.

47. Indicate below any jurisdiction in which you **currently hold or have ever held a dental license.** Have each board where you currently hold or have ever held a dental license send a certification of your license directly to the Louisiana State Board of Dentistry.

Jurisdiction	Licensed by (examination, credentials, etc.)	License no. and date issued	Years of practice	Type of practice

48. Provide your current DEA registration information. If you do not have one, select N/A. ☐ N/A
Attach a copy of your current DEA registration certificate.
If you need additional space, attach another sheet to this application.

DEA registration number: _____

Issue date: _____ Expiration: _____

49. Provide any current state controlled substances permit information. If you do not have one, select N/A. ☐ N/A
Attach a copy of your current state controlled substances permit(s).
If you need additional space, attach another sheet to this application.

Permit number: _____ State: _____

Issue date: _____ Expiration: _____

50. Are you currently in compliance with continuing education requirements in any current state of licensure. Attach proof of CE completed within the past two years to demonstrate this compliance. ☐ Yes ☐ No
If no, please contact the Board office before submitting your application.

51. Have you had any malpractice or negligence lawsuits or claims brought against you, whether the claim or lawsuit was made against you directly or any practitioner by whom you were employed, or any entity by whom you were employed, within the last ten (10) years with dates and results, including settlements or resolution. ☐ Yes ☐ No
If yes, provide your explanation. Include all cases that were dismissed or were settled without payment. Include active and pending cases. Provide a statement and documentation.
A "YES" ANSWER **MUST** BE EXPLAINED IN DETAIL IN A RIDER. Provide your explanation.
Include all cases that were dismissed or were settled without payment. Include active and pending cases. Provide a statement and documentation.

52. List all malpractice insurance carriers (including addresses & policy numbers) with whom you have been insured during the past ten (10) years. Leave no time gaps. If you have had an individual policy or if you have been covered by others, (employer/group policy, military, school employment/residency, or federal/public health), indicate coverage type. Provide the name of your carrier as well as the policy number. Have each carrier provide a letter indicating your claim history directly to the Board.
If you need additional space, attach another sheet to this application.
If you have never carried malpractice insurance, nor been covered under any other policy, write "N/A."

☐ Current policy

Coverage type: _____

Carrier: _____

Policy No.: _____

Start date: _____ End date: _____

☐ Current policy

Coverage type: _____

Carrier: _____

Policy No.: _____

Start date: _____ End date: _____

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 $ 2100.00 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

AUTHORIZATION FOR THE RELEASE OF CONFIDENTIAL INFORMATION

COMPLETE THIS FORM ONLY IF YOU HAVE TESTED POSITIVE FOR HIV, HBV, OR HCV

PLEASE PRINT OR TYPE ALL INFORMATION AS REQUIRED

I authorize _____ and the physicians
Name of hospital/physician/facility

who treated _____ to release to
Name of patient

Louisiana State Board of Dentistry
P.O. Box 5256
1201 North Third Street
Suite G-136
Baton Rouge, Louisiana 70821-5256
(225) 219-7330

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 46:XXXIII.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 46:XXXIII.1208.

_____ _____
Patient signature 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

CERTIFICATION OF DENTAL LICENSURE

Louisiana State Board of Dentistry
P.O. Box 5256 ◆ Baton Rouge, Louisiana 70821-5256
(225) 219-7330

This form must be completed by each state where you currently hold or have ever held a dental license. This form should be mailed directly from the board by which you are licensed or may accompany your application in a sealed envelope from that board office.

Applicant: Complete the top portion and then forward this form to the jurisdiction where you are requesting certification of licensure. Some jurisdictions charge a fee, so please call to confirm the procedure for submitting this form.

Licensing board: Please complete the requested information and then return this form directly to the Louisiana State Board of Dentistry or to the applicant in a sealed envelope. ***The Louisiana State Board of Dentistry will accept other forms of certification if all information requested in this form is included.***

TO BE COMPLETED BY APPLICANT

Name: _____

Mailing address: _____

_____

_____ _____
Applicant signature Date

TO BE COMPLETED BY LICENSING BOARD REPRESENTATIVE

I, _____, Representative of the _____

hereby certify that _____ was granted certificate/license number _____ to practice dentistry in the state of _____ on the _____ day of _____, _____.

Said license was granted on the basis of _____.

Has this licensee ever been the subject of any disciplinary action? ☐ Yes ☐ No
If yes, please attach a copy of documentation.

Is there any disciplinary action currently pending? ☐ Yes ☐ No
If yes, please attach a copy of documentation.

Is license current? ☐ Yes ☐ No

Expiration date _____

_____ _____
Board representative signature Date

Board seal

_____
Title

NOTARIZED AFFIDAVIT FOR PROOF OF CLINICAL PRACTICE

This affidavit must NOT be completed by the applicant.
This affidavit must be completed by a dentist who has seen your work. It may not be completed by a relative or an instructor whose knowledge of your dental work was solely through your time in dental school.

APPLICANT NAME: _____

I, _____, the undersigned, do of my own personal knowledge make the following statements and declare them to be true.

1. My profession is _____.
2. I have known _____ for the time period _____ to
   (*applicant's name)*
   _____.
3. The nature of my relationship to the applicant is _____

   _____
4. I have direct, personal knowledge of said applicant's practice as a dentist.
5. I can attest to the applicant's satisfactory practice as a dentist and recommend him/her for a dental license in Louisiana.
6. The following contact information is the most current and valid for me to be reached for further verification of any information relating to this affidavit.

   _____
   Address City State ZIP

   _____
   Area Code Telephone Ext.

_____
Affiant signature

Sworn 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.

Return completed, notarized affidavit to
Louisiana State Board of Dentistry
P.O. Box 5256
Baton Rouge LA 70821-5256

NOTARIZED AFFIDAVIT
PENDING COMPLAINT/INSURANCE INFORMATION

This affidavit must be completed by the applicant.

STATE OF: _____

PARISH/COUNTY OF: _____

BEFORE ME, the undersigned authority came and appeared:

_____
(applicant name)

who, after being by me first duly sworn, did depose and say:

Affiant has declared that there are no unresolved complaints against him/her and his/her liability insurance has never been revoked, modified, or non-renewed.

_____
Affiant signature

Sworn and subscribed to before me on this _____ day of _____,

20_____, to certify which witness my hand and official seal of office.

_____
Notary public

_____
My commission expires

SEAL

Return completed, notarized affidavit to
Louisiana State Board of Dentistry
P.O. Box 5256
Baton Rouge LA 70821-5256

Physician's Statement of Examination

The following is to be completed by your physician and included with your application packet.

I, _____, being a duly licensed physician in the state of _____, have this day examined _____, the applicant herein, and my medical examination reveals that such applicant is free from all infectious and contagious diseases, and such applicant is in good physical and mental health.

Examination is made in _____
City State

On this _____ day of _____, 20_____.

License number: _____

_____
Physician signature