South Dakota State Board of Dentistry
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DENTIST OR DENTAL HYGIENIST APPLICATION FOR VOLUNTEER REGISTRATION

This application is for a dentist or dental hygienist who intends to practice in South Dakota on a temporary volunteer basis. Please be sure to submit all required information and fees with this application. Applications will be closed if all required information is not received within twelve months.

Links to the statutes and administrative rules that govern the profession, often referred to as the Dental Practice Act, are available on our website.

The Board of Dentistry will carefully review each application for licensure. If the applicant has an unresolved disciplinary complaint pending before a dental board, a registration will not be issued. Please note that intentional failure to provide complete information or concealment of relevant information needed by the Board for a thorough review of credentials may result in denial of an application or may be considered as the basis for revocation of any registration which may have been issued.

After reviewing this application and checklist below, please contact our office if you have any questions.

VOLUNTEER REGISTRATION CHECKLIST:

The following must be submitted before your application will be processed. You must submit a completed application and all supporting documents **at least thirty days** prior to the date(s) of service to allow for processing:

1) Completed application with a $100.00 application fee;
2) A copy of your birth certificate;
3) If applicable, a copy of any name change;
4) A verification letter from the licensed South Dakota dentist you will be assisting that verifies the dates of your service;
5) A copy of your current cardiopulmonary resuscitation (CPR) card. This card must be valid through the dates of service and be one of the following:
    a. A CPR course intended for a Healthcare Provider that meets the required knowledge and objectives outlined in the American Heart Association guidelines for BLS or American Heart Association Guidelines for CPR and ECC, and includes a hands-on skills assessment; or
    b. An American Heart Association ACLS; or
    c. An American Heart Association PALS.
6) A verification letter from your state dental licensing board that verifies you are a dentist or dental hygienist licensed in that state and that your license is in good standing. This letter must be mailed from your state dental licensing board directly to the South Dakota State Board of Dentistry office. States that only offer electronic verification should send it to the email address above.

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Name: _____ ☐ Dentist ☐ Dental Hygienist

Name of Primary Office: _____

Office Address: _____

City: _____ State: _____ Zip: _____

Office Phone: _____ Date of Birth: _____ Social Security Number: _____

E-mail address: _____
(E-mail address will not be shared with anyone and will only be used to facilitate contact)

Where in South Dakota will you be working?

Name of South Dakota Office: _____

Office Address: _____

City: _____ State: South Dakota Zip: _____

Office Phone: _____ Fax: _____

Is this a mobile dental unit? Yes No

If yes, authorization to operate a mobile dental unit may be necessary. Please contact our office immediately.

Date(s) of service:

From: _____ To: _____

From: _____ To: _____

From: _____ To: _____

I have attached a copy of the following CPR card (please select one):

☐ A CPR course that meets the following requirements:

1) is intended for a Healthcare Provider; and
2) meets the required knowledge and objectives outlined in the American Heart Association guidelines for BLS or American Heart Association Guidelines for CPR and ECC; and
3) includes a hands-on skills assessment

☐ American Heart Association ACLS

☐ American Heart Association PALS

☐ **Yes** ☐ **No** This CPR card is valid through all dates of service listed above.

Please list the state(s) in which you currently practice:

STATE_____LICENSE #_____DATE RECEIVED_____STATUS_____
STATE_____LICENSE #_____DATE RECEIVED_____STATUS_____
STATE_____LICENSE #_____DATE RECEIVED_____STATUS_____

Please check one:

☐ I hereby certify that I have completed more than 1,500 clinical practice hours during the five years immediately preceding this application.

OR

☐ I hereby certify that I have graduated from an ADA CODA accredited United States dental or dental hygiene school within three years preceding the date of application.

1. Has any license, registration, permit or certificate held by you in any state or country been denied, revoked, suspended, stipulated, or have you been placed on probation or otherwise subjected to any type of disciplinary or corrective action? ☐ Yes ☐ No

2. Are you currently being investigated or is disciplinary action pending against any professional license(s) or certificate(s) held by you? ☐ Yes ☐ No

3. Have you ever been denied a license to practice in another state? ☐ Yes ☐ No

4. Have you individually, or through your dental entity, been subject to a negligence or malpractice judgment or settlement during the scope and course of your practice? ☐ Yes ☐ No

5. Have you ever been convicted, pled no contest/nolo contendere, pled guilty to, or been granted a deferred judgment or suspended imposition of sentence or had prosecution deferred with respect to a felony or a misdemeanor, other than a class 2 misdemeanor traffic offense? ☐ Yes ☐ No

6. Is there any pending criminal prosecution against you? ☐ Yes ☐ No

7. Have you ever had privileges revoked, reduced, or otherwise restricted at any hospital or other healthcare provider entity? ☐ Yes ☐ No

I have read the foregoing document and have answered all questions fully and completely. I declare and affirm under the penalties of perjury that this application has been examined by me, and to the best of my knowledge and belief, is in all things true and correct. I understand that falsification or omission of information, including intentional failure to provide complete information or concealment of relevant information needed by the Board for a thorough review of credentials, may result in denial of my application or may be considered as the basis for revocation of any registration which may have been issued.

Signature: _____ Date: _____

Printed Name:_____

Mail completed application and $100.00 application fee to:
South Dakota State Board of Dentistry
PO Box 1079
Pierre, SD 57501

For Office Use Only:
Check # _____
Amount _____
Date _____

For questions 1-7 on page 3, please provide a detailed explanation for each YES response in the space provided below. You must include a complete description of dates and events. If you have more than one violation to report, you must list the violations in chronological order (most recent first). If you need additional space, please attach additional sheets as necessary.

You must also submit copies of all communications (to and from) the citing agency or board, including evidence of completion/compliance with requirements. You must group the documents by violation and put them in chronological order (most recent first).