



## South Dakota State Board of Dentistry

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### **DENTAL LICENSE APPLICATION**

This application is for a dentist that has taken a patient based or equivalent manikin based clinical competency examination within the five years preceding application. Please be sure to submit all required information and fees with this application. Once your application and fees are received in our office, and an initial review is completed, you will receive a confirmation email with information related to your specific application. Applications will be closed if all required information is not received within twelve months.

If you are an active duty member of the armed forces of the United States or the spouse of an active duty member of the armed forces of the United States who is the subject of a military transfer to South Dakota and hold a license or registration in good standing to practice as a Dentist in another state, please contact our office for an Active Duty Military Personnel or Spouse License or Registration Application.

Individuals applying for a license to practice as a dentist are required to complete a criminal background check. *Please contact our office to obtain a criminal background check information packet, including instructions and fingerprint cards.* The fingerprint cards you receive from our office must be the cards you use for fingerprints, since specific agency data is pre-printed on them. Contact your local law enforcement agency for fingerprinting and then send to our office the completed fingerprint cards and a money order (no cash or checks) payable to the South Dakota Division of Criminal Investigation (DCI). You will not be issued a temporary registration until acceptable results of the criminal background checks are received in the Board office from the Federal Bureau of Investigation (FBI).

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 Jurisprudence Exam questions are taken directly from the Dental Practice Act. Once our office receives your application and the required Jurisprudence Examination fee, you will be emailed a link to take the examination. Please be sure the email listed on this application is correct. This exam must be completed by the applicant. *This is an open book examination intended to acquaint the applicant with the statutes and administrative rules related to the practice of dentistry. This examination is not timed. An applicant is able to start the exam, save it, and complete it at a later time.*

Applications will be reviewed at the next board meeting if all materials, including all required documents, the results of the Jurisprudence Exam, and the criminal background check, are received 30 days prior to that meeting. If requested, an applicant must appear for a personal interview with the Board. Board meeting dates and times are listed on the Board's website.

A dentist must obtain a permit from the Board to administer general anesthesia or deep sedation, moderate sedation, nitrous oxide sedation and analgesia or hold a host permit. Applications are available on the Board's 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 license 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 discipline, including but not limited to revocation of any license which may have been issued. The Board may require a laboratory or clinical examination if it has reason to believe an applicant cannot practice safely.

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

## **DENTAL LICENSE APPLICATION CHECKLIST:**

The following must be submitted before your application will be processed:

1. A copy of applicant's National Board Dental Examination results. *Verification of passage of the National Board Dental Examination Parts I and II or the Integrated National Board Dental Examination results must be sent directly to our office from the Joint Commission on National Dental Examinations.*
2. A copy of the applicant's patient based or equivalent manikin based clinical competency examination results. *The applicant must have passed the patient based or equivalent manikin based clinical competency examination within the five years prior to application. The examination results must be sent directly to our office from the testing agency or must be accessible online. Please be advised that the examination must meet criteria outlined in administrative rule to be accepted for licensure. Please confirm with the testing agency that all required components outlined in administrative rule are included.*
3. Verification of the license number and status of your license from the board of dentistry in each state in which you are or have been licensed. *The applicant must request a verification letter from each state in which the applicant is or has been licensed if that state does not provide online verification. Each letter must be certified and sent directly to our office from the respective board of dentistry.*
4. Certified transcripts from an American Dental Association Commission on Dental Accreditation accredited United States dental school or a certified letter from the school verifying the applicant's graduation status. *The transcripts or certified letter must be sent directly to our office from the school. Electronic transcripts are accepted.*
5. A copy of the applicant's birth certificate or equivalent documentation.
6. If applicable, documentation of any name change. (i.e. marriage license)
7. A copy of applicant's current cardiopulmonary resuscitation (CPR) card. *An approved CPR course is a 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.*
8. A completed South Dakota Jurisprudence Examination. *Once your application is received, you will be emailed a link to the Jurisprudence Examination, along with links to the statutes and administrative rules covered by the examination.*
9. A \$200.00 dental license application fee along with a \$300.00 Jurisprudence Examination fee made payable to the South Dakota State Board of Dentistry.
10. Completed fingerprint cards and a \$43.25 money order made payable to the South Dakota Division of Criminal Investigation for the criminal background check.
11. If applicable, a \$100.00 temporary registration application fee. *This fee is waived for applicants that have graduated within 6 months prior to application.*

**SOUTH DAKOTA STATE BOARD OF DENTISTRY  
DENTAL LICENSE APPLICATION**

You must answer every question on this application or your application will be returned.  
If additional space is needed, please attach additional sheets.

Name (First, Middle, Last): \_\_\_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Email: \_\_\_\_\_

*This email will be used to correspond with you regarding your application. Please be sure the email is current.*

If known, office you intend to practice at in South Dakota: \_\_\_\_\_

Office Address: \_\_\_\_\_ Office Phone: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Do you intend to practice dentistry in South Dakota:      Full Time      Part Time      Temporary      Not at all

If part time, how many hours monthly? \_\_\_\_\_

Start date, if known: \_\_\_\_\_

Yes      No. I am requesting a temporary registration and a fee of \$100 has been included with this application. *This fee is waived for applicants that have graduated within 6 months prior to application.*

**Dental School:**

Date of Dental Diploma: \_\_\_\_\_

Name of School: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Specialty – Residency/Program:** *Please attach proof of postdoctoral training*

Specialty: \_\_\_\_\_

Name of School/Program: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Date From: \_\_\_\_\_ Date To: \_\_\_\_\_ Date of Completion: \_\_\_\_\_

**Other educational institution attended:**

Name of School: \_\_\_\_\_ Degree: \_\_\_\_\_

Date From: \_\_\_\_\_ Date To: \_\_\_\_\_ Date of Completion: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Patient Based or Equivalent Simulation or Manikin Based Clinical Competency Examination:**

I passed the following patient based or equivalent simulation based or manikin based clinical competency examination that meets the requirements outlined in 20:43:03:02: \_\_\_\_\_

Yes No. I passed the above referenced clinical competency examination within five years preceding application.

**Please Select One:**

Documentation of passage of the above referenced clinical competency examination, *including verification from the testing agency that all requirements outlined in ARSD 20:43:03:02 have been met*, has been requested and is being sent directly to the Board office from the entity that administered the examination or

Documentation of passage of the above referenced clinical competency examination, *including verification from the testing agency that all requirements outlined in ARSD 20:43:03:02 have been met*, can be accessed online through the entity that administered the examination.

Yes No. I failed a part of a patient based or equivalent simulation based or manikin based clinical competency examination. If yes, please include verification from the entity that administered the examination listing the examination taken, date(s) taken and reason(s) for failure. *Note: An applicant who fails any combination of clinical competency examinations three times is not eligible for licensure in South Dakota.*

**Active Practice:**

Yes No. Do you currently hold a valid license issued by a different state or the District of Columbia to practice as a dentist?

Please submit the following information for each state in which you have been licensed as a dentist.

STATE _____	LICENSE # _____	DATE RECEIVED _____	STATUS _____
STATE _____	LICENSE # _____	DATE RECEIVED _____	STATUS _____
STATE _____	LICENSE # _____	DATE RECEIVED _____	STATUS _____

*You must also submit a certified letter verifying the license number and status of your license from the board of dentistry in each state in which you have been licensed if that state does not provide online verification. These letters must be sent directly to our office from the licensing body.*

**Military Service:**

Are you an active duty member or the spouse of an active duty member of the armed forces of the United States? Yes No

If yes, were you or your spouse the subject of a military transfer to South Dakota?

Yes No N/A

**Employment History - Dentist:** Please list in chronological order. If you need additional space, please attach additional sheets.

Employer Name: \_\_\_\_\_  
Current Address: \_\_\_\_\_  
Current Telephone Number: \_\_\_\_\_  
Position Held: \_\_\_\_\_  
Reason for Termination/Resignation: \_\_\_\_\_  
Dates Employed – From: \_\_\_\_\_ To: \_\_\_\_\_  
Total Dental Clinical Practice Hours Provided For this Employer *During the Last Five Years:* \_\_\_\_\_

Employer Name: \_\_\_\_\_  
Current Address: \_\_\_\_\_  
Current Telephone Number: \_\_\_\_\_  
Position Held: \_\_\_\_\_  
Reason for Termination/Resignation: \_\_\_\_\_  
Dates Employed – From: \_\_\_\_\_ To: \_\_\_\_\_  
Total Dental Clinical Practice Hours Provided For this Employer *During the Last Five Years:* \_\_\_\_\_

Employer Name: \_\_\_\_\_  
Current Address: \_\_\_\_\_  
Current Telephone Number: \_\_\_\_\_  
Position Held: \_\_\_\_\_  
Reason for Termination/Resignation: \_\_\_\_\_  
Dates Employed – From: \_\_\_\_\_ To: \_\_\_\_\_  
Total Dental Clinical Practice Hours Provided For this Employer *During the Last Five Years:* \_\_\_\_\_

**Other Licenses:**

Yes      No. Have you ever held a license other than a license to practice as a dentist?

If yes, please submit the following information for each state in which you have held a license other than a license to practice as a dentist.

STATE _____	LICENSE # _____	DATE RECEIVED _____	STATUS _____
STATE _____	LICENSE # _____	DATE RECEIVED _____	STATUS _____

**CPR:**

By initialing below, I hereby attest that the CPR course I am submitting a card for meets all of the following requirements:

- \_\_\_\_\_ Is a Basic Life Support course intended for a Healthcare Provider; and
- \_\_\_\_\_ Included knowledge and objectives in accordance with the American Heart Association Guidelines for BLS or American Heart Association Guidelines for CPR and ECC; and
- \_\_\_\_\_ Included a hands-on skill assessment.

1. 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?	(Check One) Yes No
2. 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 misdemeanor other than a class 2 misdemeanor traffic offense? *It is the applicant's responsibility to confirm whether the infraction is a class 1 or class 2 misdemeanor.	Yes No
<p><b>Please note:</b> If you answered YES to 1 or 2, provide a personal statement detailing the nature of the crime, whether you think the crime relates to your practice, and description of rehabilitation efforts. You must also submit copies of charges or citations and ALL communications (to and from) the citing agency AND the court of jurisdiction, including evidence of completion/compliance with court requirements. You must attach all communications for a violation to the signed and dated explanation of that violation. Please put correspondence in chronological order (most recent first). If you have more than one violation, please do the same for each violation.</p> <p><b><i>This does not include records that have been sealed, expunged, or pardoned.</i></b></p>	
3. Is there any pending criminal prosecution against you?	Yes No
4. Are you currently being investigated or is disciplinary action pending against any professional license(s) or certificate(s) held by you?	Yes No
5. 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 action?	Yes No
6. Have you ever been denied a license to practice in another state?	Yes No
7. Have you ever appeared or been requested to appear before any licensing board concerning any violation of law or regulation of any state district, territory or province of the United States or Canada?	Yes No
8. Have you ever had privileges revoked, reduced, or otherwise restricted at any hospital or other healthcare provider entity?	Yes No
9. Have you ever been subject to proceedings by a professional society to revoke, reduce or restrict membership?	Yes No
10. 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
11. Are you currently engaged in the illegal use of drugs?	Yes No
12. Does your use of alcohol adversely affect your ability to practice currently?	Yes No
13. Are you currently participating in a supervised rehabilitation program or case management/monitoring program for a mental health or substance use related issue or disorder?	Yes No

14. Are you currently suffering from any condition for which you are not being treated that impairs your ability to practice in a competent, ethical, and professional manner?	Yes    No
15. Do you currently owe child support arrearages in the amount of \$1,000 or more?	Yes    No
16. Have you had adverse action or ethical violation(s) during any education, residency or training program?	Yes    No
17. Have you ever been released from the military by any means other than an honorable discharge?	Yes    No
18. Are you in any way using fraud or deception in applying for a license to practice in South Dakota?	Yes    No
<b>Please note:</b> For questions 3-18 above, provide an explanation for each YES response on a separate piece of paper, with a complete description of dates and events. You must also send all supporting applicable documents. You must attach supporting documents to the signed and dated explanation. Please put supporting documents in chronological order (most recent first).	

I, \_\_\_\_\_, the applicant, being first duly sworn, certify that I am the person referred to in this application, that under penalty of perjury all the information contained in this application and in any attachments or additional documents submitted herewith is true and correct and that all persons and organizations whether public or private, are authorized to release to the South Dakota State Board of Dentistry all information, files or records requested in connection with this application.

Applicant Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Subscribed and sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_ 20\_\_\_\_\_

My commission expires \_\_\_\_\_

\_\_\_\_\_  
Notary Public

**Attach Photo Here**  
 For identification purposes, the applicant shall furnish one passport size photograph taken not more than six months before the date of application.

**Electronic Notary Statement, if applicable:**

On this \_\_\_\_ day of \_\_\_\_\_, in the year \_\_\_\_\_, before me, \_\_\_\_\_, the undersigned office appeared \_\_\_\_\_ with a remote location of \_\_\_\_\_ (city/state), whom I have personal knowledge by identity proofing and whom I positively identified as the person whose name is subscribed to the within instrument, appeared before me not in my physical presence but by means of a tamper-evident electronic notarization system, and I observed his/her execution of the same for the purposes contained therein and confirm that I affix my official seal to the same instrument so executed.

## Authorization and Release

I, \_\_\_\_\_, having filed an application for a license to practice as a dentist in the state of South Dakota, hereby apply for verification of my credentials and consent to have an investigation made as to my moral character, professional reputation and fitness for the practice of dentistry. I agree to give any further information which may be required in reference to my past record. I understand that I will not receive and am not entitled to a copy of the investigative report or to know its contents and I further understand that the content of the report is privileged and confidential. I understand that I will be afforded a reasonable opportunity to rebut or explain any adverse information disclosed by the investigation.

I also authorize and request every person, firm, company, corporation, governmental agency, court, association or institution having control of any documents, records, and other information, or pertinent data to permit the South Dakota State Board of Dentistry or any of its agents or representatives to inspect and make copies of such documents, records, and other information.

I hereby release, discharge, and hold harmless the South Dakota State Board of Dentistry, its agents and representatives, and any other person so furnishing information from any and all liability of every nature and kind arising out of the furnishing or inspection of such documents, records and other information.

I understand that the South Dakota State Board of Dentistry cannot accept any altered Authorization and Release forms.

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 discipline or revocation of any license which may have been issued.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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

For Office Use Only:  
Check # \_\_\_\_\_  
Amount \_\_\_\_\_  
Date \_\_\_\_\_



**CERTIFICATE OF MORAL CHARACTER:**

This certifies that I have personally known \_\_\_\_\_ for \_\_\_\_\_ years and that I believe him or her to be of good moral character and that I am not related to him or her by kinship or marriage.

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

This certifies that I have personally known \_\_\_\_\_ for \_\_\_\_\_ years and that I believe him or her to be of good moral character and that I am not related to him or her by kinship or marriage.

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*For questions 1-21 on pages 6 & 7, 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).*