South Dakota State Board of Dentistry
P.O. Box 1079, 1351 N. Harrison Ave. Pierre, SD 57501-1079
Ph: 605-224-1282 Fax: 1-888-425-3032

E-mail: contactus@sdboardofdentistry.com www.sdboardofdentistry.org

APPLICATION FOR DENTAL LICENSE BY CREDENTIAL VERIFICATION

This application is for individuals that are currently licensed in another state that have completed a minimum of three thousand dental clinical practice hours within the five years immediately preceding the date of 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.

APPLICATION FOR DENTAL LICENSE BY CREDENTIAL VERIFICATION CHECKLIST:

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

1. A statement from a healthcare provider (MD, DO, CNP, or PA) attesting to the applicant's physical and mental condition. *Only the form provided in this application will be accepted.*

2. A copy of applicant's National Board Dental Examination scores. *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 or must be accessible online.*

3. A copy of the applicant's patient based or equivalent manikin based clinical competency examination results. *The examination results must be sent directly to our office from the testing agency or must be accessible online.*

4. 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.*

5. Certified transcripts from an American Dental Association Commission on Dental Accreditation accredited United States dental school. *The transcripts must be sent directly to our office from the school and contain verification of ADA CODA status at time of graduation. Electronic transcripts are accepted.*

6. A copy of the applicant's birth certificate or equivalent documentation.

7. If applicable, documentation of any name change. (i.e. marriage license)

8. A copy of the 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.*

9. A completed South Dakota Jurisprudence Examination. *Once the application is received, the applicant will be emailed a link to the Jurisprudence Examination, along with links to the statutes and administrative rules covered by the examination.*

10. A $600.00 dental license application fee along with a $300.00 Jurisprudence Examination fee made payable to the South Dakota State Board of Dentistry.

11. Completed fingerprint cards and a $43.25 money order made payable to the South Dakota Division of Criminal Investigation for the criminal background check.

12. If applicable, a $100.00 temporary registration application fee.

SOUTH DAKOTA STATE BOARD OF DENTISTRY
APPLICATION FOR DENTAL LICENSE BY CREDENTIAL VERIFICATION

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

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? _____

State date, if known: _____

☐ Yes ☐ No. I am requesting a temporary registration and a fee of $100 has been included with this application.

Dental School:

Date of Dental Diploma: _____

Name of School: _____

City: _____ State: _____ Zip: _____

Transcripts and verification of ADA CODA status at time of graduation have been requested. ☐ Yes ☐ No

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: _____

Clinical Examination:

I passed the following patient-based, simulation-based, or manikin-based clinical competency based clinical competency examination: _____ Year: _____

Please Select One:

☐ Documentation of passage of the above referenced clinical competency examination 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 can be accessed online through the entity that administered the examination.

Active Practice:

☐ Yes ☐ No I hereby certify that I have completed more than 3,000 dental clinical practice hours during the five years preceding this application. The Board will accept clinical practice hours completed during an ADA Commission on Dental Accreditation (CODA) accredited residency program. *If requested, you will need to provide verification from your employer(s) or school.*

☐ 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 are or have been licensed. If additional space is needed, please attach additional sheets as necessary.

STATE_____LICENSE #_____DATE RECEIVED_____STATUS_____
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.***

Please list all present and past memberships in dental associations:

_____

_____

_____

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

<u>Employment History - Dentist</u>: 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***: ______

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***: ______

<u>Other Licenses</u>:

☐ 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______

<u>CPR:</u>
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.

	(Check One)
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?	☐ 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
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. In the five years prior to application, have you engaged in the illegal use of drugs?	☐ Yes ☐ No
12. Are you currently engaged in the illegal use of drugs?	☐ Yes ☐ No
13. In the five years prior to application, has your use of alcohol adversely affected your practice of the profession?	☐ Yes ☐ No
14. Does your use of alcohol adversely affect your ability to practice currently?	☐ Yes ☐ No
15. In the five years prior to application, have you completed a supervised rehabilitation program for drugs or alcohol?	☐ Yes ☐ No
16. Are you currently participating in a supervised rehabilitation program for drugs or alcohol?	☐ Yes ☐ No
17. Have you experienced a physical, emotional, or mental condition that has adversely affected your practice or endangered the health or safety of your patients in the five years prior to application?	☐ Yes ☐ No

18. Do you currently owe child support arrearages in the amount of $1,000 or more?	☐ Yes ☐ No
19. Have you had adverse action or ethical violation(s) during any education, residency or training program?	☐ Yes ☐ No
20. Have you ever been released from the military by any means other than an honorable discharge?	☐ Yes ☐ No
21. Are you in any way using fraud or deception in applying for a license to practice in South Dakota?	☐ Yes ☐ No
For questions 1-21 on above, please provide a detailed explanation for each YES response in the space provided at the end of this application. You must also submit copies of all communications (to and from) the citing agency or board, including evidence of completion/compliance with requirements.	

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.

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: _____

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To Whom It May Concern:

The South Dakota State Board of Dentistry is conducting a review of the professional credentials of an applicant for a license to practice as a dentist or dental hygienist in the State of South Dakota. One of the requirements for licensure is a statement by a licensed MD, DO, PA or CNP that the applicant has been examined and found physically and mentally acceptable to safely practice as a dentist or dental hygienist.

Please examine the applicant, at his or her own expense, and provide your professional assessment of the applicant's fitness to practice as a dentist or dental hygienist by completing the form below.

Medical Evaluation of License Applicant

Applicant's Name: _____

Date of Medical Evaluation: _____

Please place a check mark in the box next to the statement that applies.

☐ I have examined the above named applicant and find no medical or mental condition, which precludes the ability to safely practice as a dentist or a dental hygienist. My examination reveals that the applicant is not chemically dependent, nor do I find that the applicant has any physical or mental disabilities.

☐ I have examined the above named applicant and have found conditions which may have an impact on this person's ability to safely render health care to patients as a dentist or dental hygienist. Please see the attached document outlining the conditions that were found.

_____ _____

Name of Office Address

_____ (_____)_____

City, State, Zip Office Phone Number

_____ _____ _____

Name License # State

I am licensed as a (circle one): MD DO PA CNP

_____ _____

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).