

**DENTIST – 2016**  
**STATE OF NEW HAMPSHIRE - BOARD OF DENTAL EXAMINERS**  
**APPLICATION FOR REGISTRATION AND LICENSE RENEWAL**

FOR OFFICE USE ONLY

PAID \$ \_\_\_\_\_  
CASH, CHECK OR MO # \_\_\_\_\_

**RENEWAL APPLICATIONS WILL BE RETURNED IF NOT COMPLETED OR MARKED "N/A"**

To avoid delays and fees, please read the instructions, type or print the requested information, and return no later than March 31, 2016 to the New Hampshire Board of Dental Examiners, 121 South Fruit Street, Concord, NH 03301. [ Between April 1 – 30, 2016, you must pay a \$200 late fee for active and \$40 late fee for inactive. ]

**REGISTRATION FEE:**

Please check one of the following:

(ACTIVE) \$365.00 -  (INACTIVE) \$145.00

**MAKE CHECK PAYABLE TO:**

**"TREASURER, STATE OF NEW HAMPSHIRE"**

Mailing address (if different)

If you would like to let this license lapse, please sign here and return the form to the Board's office with no further entries. \_\_\_\_\_.

Name \_\_\_\_\_ License # \_\_\_\_\_

(Active/Inactive) \_\_\_\_\_ Original Date of NH License \_\_\_\_\_

Have you practiced in New Hampshire since April 1, 2014? Yes \_\_\_\_\_ No \_\_\_\_\_

If no, you must register as inactive unless this is your first biennial registration.

Do you practice as a specialist? Yes \_\_\_\_\_ No \_\_\_\_\_ Specialty \_\_\_\_\_

Do you hold an active license in another state? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, indicate where: \_\_\_\_\_

Do you hold an inactive license in another state? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, indicate where: \_\_\_\_\_

In what hospitals do you have staff privileges? If none please indicate \_\_\_\_\_

**Primary Residence:**

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

City/State/ZIP: \_\_\_\_\_

Telephone: \_\_\_\_\_

**Primary New Hampshire Practice Location:**

Name of Practice: \_\_\_\_\_

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

City/State/ZIP: \_\_\_\_\_

Telephone: \_\_\_\_\_

Primary email address (either business or personal): \_\_\_\_\_

**Additional Practice Locations Including Out-of-State:**

Name of Practice: \_\_\_\_\_

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

City/State/ZIP: \_\_\_\_\_

Telephone: \_\_\_\_\_

Name of Practice: \_\_\_\_\_

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

City/State/ZIP: \_\_\_\_\_

Telephone: \_\_\_\_\_

- Have you ever been convicted of any felony, misdemeanor, or driving under the influence of alcohol or drugs which has not been annulled? Yes \_\_\_\_\_ No \_\_\_\_\_
- Have you ever been convicted of the illegal practice of dentistry? Yes \_\_\_\_\_ No \_\_\_\_\_
- Have you ever been denied dental licensure? Yes \_\_\_\_\_ No \_\_\_\_\_
- Including in New Hampshire, have you ever been or are you currently subjected by a professional licensing body to any investigation (excluding dismissed complaints), sanction, or disciplinary action including but not limited to probation or stayed probation, limitation or restriction, fine, reprimand, or being required to submit to care, counseling, supervision or further education? Yes \_\_\_\_\_ No \_\_\_\_\_

- Including in New Hampshire, has your license to practice dentistry ever been revoked, suspended, placed under probation or stayed probation, restricted, not renewed, voluntarily or involuntarily relinquished, or otherwise sanctioned, or currently under review in any jurisdiction or state? Yes \_\_\_\_\_ No \_\_\_\_\_
- Have you ever had a DEA license that has been revoked, suspended, denied, placed on probation, restricted or otherwise sanctioned by any state or federal licensing/regulatory board or agency, or which is currently involved in an investigation or disciplinary process? Yes \_\_\_\_\_ No \_\_\_\_\_
- Have you ever been or are you currently named as a party in any malpractice or professional liability claim or lawsuit or is there any pending? Yes \_\_\_\_\_ No \_\_\_\_\_
- Have your hospital privileges ever been revoked, suspended, restricted, denied, not renewed, voluntarily or involuntarily relinquished, or are they currently under review? Yes \_\_\_\_\_ No \_\_\_\_\_
- Have you any physical or mental illness or other condition, or addiction to alcohol, narcotics or other mind altering drugs which impairs your ability to practice dentistry? Yes \_\_\_\_\_ No \_\_\_\_\_

**IF YOU ANSWERED YES TO ANY OF THE PREVIOUS QUESTIONS, PLEASE PROVIDE AN EXPLANATION OR DOCUMENTATION IF IT WAS NOT PREVIOUSLY PROVIDED.**

- Do you have a DEA number to prescribe schedule II-IV controlled substances? Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, provide DEA number: DEA # \_\_\_\_\_
- Have you registered with the New Hampshire PDMP as required in RSA 318-B:33, II and Ph 1503.01 (a)? Yes \_\_\_\_\_ No \_\_\_\_\_

**INACTIVE LICENSEES**

Inactive licensees are not required to report use of anesthesia/sedation, ownership interest, and continuing education.

**USE OF ANESTHESIA AND SEDATION:**

Do you use or employ general anesthesia, deep sedation or moderate sedation on an outpatient basis for dental patients in New Hampshire?

*If you hold a permit, to renew please send a \$35 fee for each location.*

General Anesthesia/Deep Sedation:	Yes _____	No _____
Moderate Sedation, Restricted	Yes _____	No _____
Moderate Sedation, Unrestricted	Yes _____	No _____

If yes, have you received a permit? Yes \_\_\_\_\_ No \_\_\_\_\_

If you hold a Moderate Sedation permit, please answer the following question:

Pursuant to Den 304.02 (d) and (e), have you documented 12 cases in the biennium or 4 hours of continuing education in sedation training? Yes \_\_\_\_\_ No \_\_\_\_\_

- **(Please attach required documentation for a moderate sedation permit.)**

**Ownership Interest**

Pursuant to RSA 125:25-c, dentists who have an ownership interest in any entity which provides diagnostic or therapeutic services shall disclose such interest to the Board of Dental Examiners upon application for or renewal of a dental license.

Excluding in-office ancillary services, do you have such an ownership interest?

Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, pursuant to RSA 125:25-c, I, please attach a list of ALL diagnostic and therapeutic services in which you have an ownership interest.

**SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

CONTINUING EDUCATION

Den 403.04 RENEWAL AND MONITORING.

**“A renewal license shall not be issued to an active licensee if the continuing education requirements were not met.”**

Anyone who initially licensed between 04/01/2014 and 04/30/2016 does not need to report CEUs. Any CEUs obtained during that period cannot be used for the next registration.

**NOTE:**

1. Dentists with an active license are required to report 40 CEUs biennially – at least 30 shall be clinical in nature.
2. 10% (4 CEUs) can be used only once for general attendance during the biennium.
3. Basic life support for healthcare providers (BLS-HCP) is considered clinical, limited to 3 CEUs each year and is required with a maximum of 6 CEU's per biennium (Den 403.03 and 403.07 (b)).
4. Audio visual is limited to 30% (12 CEUs) of the required total (Den 403.07 (g)). Audio visual programs must include the successful completion of a written exam.
5. 2 CEU's shall be earned in infection control during the biennium.

Please provide and attest by your signature the following information for the period April 1, 2014 – April 30, 2016:

1. I have completed 40 or more CEUs, at least 30 of which were “clinical” in nature (see Den 403.02, Definition of Terms)  
Yes \_\_\_\_\_ No \_\_\_\_\_  
Clinical hrs \_\_\_\_\_ Non-clinical hrs \_\_\_\_\_
2. If your continuing education becomes complete between April 1 – 30, 2016, you must pay the late fee and complete your hours before renewing. Failure to complete the requirement before May 1, 2016 will cause your license to lapse.
3. My BLS-HCP training is current. Yes \_\_\_\_\_ No \_\_\_\_\_

**By April 1, 2016, applicants shall be certified in basic life support for healthcare providers (BLS-HCP).**

\_\_\_\_\_  
Signature

**Unless you are audited, no other continuing education information is required at this time.**

Pursuant to Den 403.03 (e), each licensee shall retain all certificates and/or documents as evidence of participation in a continuing education program or course for a period of 3 years from the date of the program course. It shall be the responsibility of each course participant to assure that verification of course participation is attained. Upon request of the Board, such documentation shall be made available to the Board or its representative for random audit and/or verification purposes.

**Continuing Education Audit**

Dentists chosen to be audited will receive an audit notice after their registration and license application is received by the Board. Those audited must show proof of continuing education within 30 days of being notified of the audit. AGD and specialty printouts are acceptable. Documentation should be sufficient to differentiate between clinical and non-clinical education hours.

The following affidavit must be completed by the applicant after the previous portion is filled out.

**STATEMENT BY APPLICANT**  
*(Must be sworn to before a notary public)*

I understand that by signing this application I am:

1. Waiving any confidentiality regarding disclosure to the Board from any other jurisdiction about any pending complaints or action being taken against my license to practice dentistry.
2. Giving consent for a criminal background check.

I, \_\_\_\_\_,  
of full age, under the penalties for falsification pursuant to RSA 641:1 through RSA 641:3, state that I am  
the person referred to in the foregoing application, that I have carefully read the instructions given and questions asked in the  
application form, and that all statements made therein are true and correct as of this

\_\_\_\_\_ of \_\_\_\_\_, 20\_\_\_\_.  
(day) (month)

\_\_\_\_\_  
Signature of Applicant

Sworn to before me and subscribed in my presence

on this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_

\_\_\_\_\_  
my commission expires: \_\_\_\_\_

Adopted: 12-9-15  
Revised: 8-3-16