

NEW HAMPSHIRE BOARD OF DENTAL EXAMINERS
121 SOUTH FRUIT STREET
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In-State Toll Free 1-800-852-3345, Ext. 4561

DENTISTS
GENERAL INFORMATION
REQUIREMENTS FOR LICENSURE
EXAMINATION or ENDORSEMENT

PLEASE READ CAREFULLY

GENERAL INFORMATION

Each applicant for licensure to practice dentistry in the state of New Hampshire must complete all of the information on the attached “**Dentist Application for Licensure**” form. The Board must have each licensee’s social security number on the “Dentist Application for Licensure” form to ensure accurate identification of the applicant’s identity. Pursuant to Federal Law 42 U.S.C.A§666(a)(13) and New Hampshire state law RSA 161-B:11, VI-a the Board may also:

1. Provide the licensee’s social security number to the Department of Health and Human Services in conjunction with proceedings or actions to establish paternity or to establish or enforce child support.
2. Provide the licensee’s social security number to National Practitioner Data Bank (NPDB) in the event of final adverse action against the licensee and to inquire of NPDB of any final adverse actions against the licensee in other jurisdictions.

Under current law an applicant’s or licensee’s social security number is confidential and not subject to the right to know law.

LICENSURE BY EXAMINATION

Any person who has successfully completed the Northeast Regional Board, or similar clinical examination acceptable to the Board of Dental Examiners with the written part of the NERB, within the **3** year period prior to completing the licensure process for a New Hampshire license, shall be considered for licensure by examination.

LICENSURE BY ENDORSEMENT CERTIFICATION

Any person holding a current, unsuspended, unrestricted license to practice dentistry in one or more states, and who has maintained an active dental practice for the **3** year period prior to completing the licensure process for a New Hampshire license, and has a history of satisfying the above license by examination requirement, shall be considered for licensure by endorsement. Dental specialty training and active military dental service are considered active dental practice.

APPLICATION FEE

A certified check or money order in the amount of **\$200.00**, made payable to the “**TREASURER, STATE OF NEW HAMPSHIRE**” must accompany the application, or if presented in person, the payment may be cash.

REQUIREMENTS FOR APPLICATION

In addition to the application form, the following documents shall be filed with the Board:

TRANSCRIPT: An official copy of the applicant’s dental school transcript, bearing the registrar’s original signature and the school’s seal, sent directly by the school to the New Hampshire Board of Dental Examiners.

NATIONAL BOARD EXAMINATION: The applicant’s original grade card, denoting successful completion of the examination, sent directly by the National Board of Dental Examiners to the New Hampshire Board of Dental Examiners. Please contact the National Board directly (1-800-621-8099) or write to: National Board of Dental Examiners, 211 E. Chicago Ave., Chicago IL 60611.

BIRTH CERTIFICATE: An original or certified copy of the applicant's birth certificate written in English or translated to English. A certified copy of a passport written in English or translated to English can be used in place of a birth certificate.

LETTER OF GOOD STANDING: A certified statement submitted directly from the Dental Board of each state in which the applicant has ever held a license (whether active, inactive, or lapsed), stating whether the applicant's license has been subject to disciplinary action, has disciplinary action pending, has been under stayed probation or is under investigation. This statement will have to be updated if more than 4 months old.

REGIONAL BOARD SCORES: If applying for licensure by examination, the applicant shall advise NERB or a similar testing agency to make his or her scores available to the Board online. Applicants must send scores from other regional boards directly to the Board's office. Passage of the written portion of NERB and passage of another regional board's clinical examination with a score of 75% or better on each part of the examination is also acceptable.

SPECIALTY TRAINING: An official copy of your specialty training certificate bearing the registrar's original signature and the school's seal or a letter on school letterhead, sent directly by the school, if you intend to declare a dental specialty in New Hampshire.

CONTROLLED DRUG PRESCRIPTION HEALTH AND SAFETY PROGRAM (PDMP):
By June 30, 2015, all applicants who after licensure obtain a DEA number to prescribe schedule II-IV controlled substances are required to register with the PDMP within 90 days of the initial issuance of a license pursuant to RSA 318-B:33, II and Ph 1503.01(a). Once obtained, licensees shall provide the DEA number to the Board. Failure to register shall constitute professional misconduct within the meaning of RSA 317-A:17, II and shall be grounds for disciplinary action.

JURISPRUDENCE EXAMINATION

After the application and **all** the supporting documents are received, the application file will be reviewed by the New Hampshire Board of Dental Examiners or its representative. If the file is acceptable to the Board or its representative, the applicant will be notified that the application is complete and that the jurisprudence examination may be taken. The applicant shall take a test on the contents of RSA 317-A Dental Practice Act, administrative rules Den 100 through Den 500, the American Dental Association's Principles of Ethics and Code of Professional Conduct, and the American Dental Hygienists' Association Code of Ethics for Dental Hygienists.

REGISTRATION

A registration fee in the amount of **\$335.00** is required at the time of licensure and each biennial registration thereafter. Certified checks or money orders should be made payable to "**TREASURER, STATE OF NEW HAMPSHIRE.**" If presented in person, the payment may be made in cash. The biennial license period for dentists commences **MAY 1st** of even-numbered years. Biennial registration requires that registration forms be mailed by the Board before February 15th of even-numbered years. Licensees are required to report a change of business or residential address and phone number within 10 days of any change to the Board.

Written notification to the Board is required.

IF YOU HAVE ANY QUESTIONS OR NEED ASSISTANCE, PLEASE CONTACT THE BOARD'S ADMINISTRATIVE OFFICE AT THE ADDRESS OR TELEPHONE NUMBER ON THE FRONT SIDE OF THIS INFORMATION SHEET.

NEW HAMPSHIRE BOARD OF DENTAL EXAMINERS
DENTIST APPLICATION FOR LICENSURE

FOR OFFICE USE ONLY
PAID \$ _____
CASH, CHECK OR MO #

Examination/Endorsement application (circle one) to practice dentistry.

False statements, knowingly made by the applicant, shall void any license issued. All questions must be completed or this application will be returned or rejected.

PRINT OR TYPE

1. Name in Full (first, middle, last) _____

2. Date of Birth (month, day, year) _____

3. Place of Birth (city, county, state) _____

4. Social Security Number _____

5. Have you ever been known by any other name? yes _____ no _____ If yes, give other name(s) _____

6. Current address: _____

Primary email address (either business or personal): _____

Day Time Telephone: _____

7. Educational background:

College _____ Date of Graduation _____

Degree, if any _____

Dental School(s)	Month and Year
_____	_____, ____ to _____, ____
_____	_____, ____ to _____, ____

I received the degree of _____ on _____
from _____

8. Post Graduate Dental Program: Type _____

Location _____ Dates _____

Degree or Specialty Training Certificate _____

9. Have you taken and passed:

The National Board	yes _____	no _____	Year _____
The NERB (written)	yes _____	no _____	Year _____
The ADEX (clinical)	yes _____	no _____	Year _____
Others (name)			
_____	yes _____	no _____	Year _____
_____	yes _____	no _____	Year _____

10. Are you currently certified in CPR? yes _____ no _____ (Please provide proof.)

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

11. List all places where you have possessed a license to practice dentistry.

If none, so state: _____

State and License No.	Issue Date	Active/Inactive	Dates of Practice
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

12. Professional Employment History

<u>Dates</u>	<u>Location</u>	<u>Status (e.g., Military, Residency, Private Practice)</u>
From _____ to _____	_____	_____
From _____ to _____	_____	_____
From _____ to _____	_____	_____
From _____ to _____	_____	_____

13. 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 _____

14. Have you ever been convicted of the illegal practice of dentistry? yes _____ no _____

15. Have you ever been denied dental licensure? yes _____ no _____

16. 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 been required to submit to care, counseling, supervision or further education? yes _____ no _____

17. 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 is currently under review in any jurisdiction or state? yes _____ no _____

18. a. Do you have any physical or mental illness that impairs your ability to practice dentistry? yes _____ no _____

b. Has a health practitioner or mental health practitioner advised you that you have any physical or mental illness that impairs your ability to practice dentistry? yes _____ no _____

19. Is your ability to practice dentistry impaired by an addiction to alcohol, narcotics, or other mind altering drugs? yes _____ no _____

20. 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 _____

21. 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 _____

22. Have your hospital privileges been revoked, suspended, restricted, denied, not renewed or involuntarily relinquished? yes _____ no _____

If you have answered yes to questions 13 through 22, attach a statement explaining the circumstances fully.

EDUCATION REQUIREMENTS

I certify that _____
(Name of Applicant)

ATTACH PHOTOGRAPH

has attended the required courses in the study of dentistry and was graduated from:

(Name of Dental School)

(Date degree conferred)

and the photograph attached is a likeness of

(Name)

(Signature of Dean, Registrar, or Secretary)

(Date)

Photograph must be a passport photo and not more than 6 months old. Seal of School must be impressed over a portion of the photograph and a portion of the application.

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

I understand that by signing the 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: _____