APPLICATION FOR LICENSE TO PRACTICE DENTISTRY

I. Applicant Identifying Information

Complete this section by providing all requested information. You must notify the Board office, in writing, of any address changes after you file this application in order to receive additional information.

Applicant’s Name _____________________________________________________________________________

Last            First               Middle             Suffix (Jr., III)

If Married, maiden name (if applicable) ___________________________ Name of Spouse ______________________

Name desired on license (if granted). ____________________________________________________________

U.S. Citizen:_______ Yes   _______ No    _____ I am not a U. S. Citizen but am a qualified alien under the federal Immigration and Naturalization Act, and I am lawfully present in the United States. *Submit copy of Green Card or Visa.

Preferred Mailing Address________________________________________________________________________

Street                  City                  County               State               Zip

Home Address_________________________________________________________________________________

Street                  City                  County               State               Zip

Home Phone (     )__________________   Cell (     )________________

Place of Birth (City, State or Country)  Date of Birth MM/DD/YYYY  Gender  M/F  Race

*Social Security Number: __________________________________________ Email: _________________________

*The Social Security Number is not subject to disclosure as public information. The disclosure of the SSN for identification purposes is authorized and mandated by federal statutes requiring state dental boards to report to the Healthcare Integrity and Protection Data Bank and the National Practitioner Data Bank.

Are you or your spouse an active duty member of the armed forces? Please attach DD214 or NGB22.

Military Service: ________________________________________________________________

Branch of Service

Honorable / Dishonorable Discharge: ___________________________ If other than Honorable, attach a copy.

Application must be completed with all requested information and documentation supplied. Application fee (check or money order) must accompany application. Application Fee is non-refundable and non-transferable.

In-State Fee — $185.00    Out-of-State Fee — $200.00    Active Duty Military Member or Spouse — $0.00

The application form is a public document subject to the Freedom of Information Act.
## II. Education Information

Pre-Dental & Dental College, School or Dental Department of a University

<table>
<thead>
<tr>
<th>Name of School</th>
<th>Location (City, State or Country)</th>
<th>From (Month/Year)</th>
<th>To (Month/Year)</th>
<th>Graduated</th>
<th>Degree</th>
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<tr>
<td>Pre-Dental</td>
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<td>Dental *</td>
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<td>Internship or Residency</td>
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<td>Other</td>
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*Please have an official dental school transcript sent directly to the Board office.*

## III. Record of Licensure Information

List all states in which you have ever been licensed, whether currently active or not. Failure to disclose all licenses held may result in denial of your application.

<table>
<thead>
<tr>
<th>State**</th>
<th>Date Issued</th>
<th>License No.</th>
<th>Expiration Date</th>
<th>Active or Inactive</th>
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**You must have a certified letter of good standing, bearing the State’s seal, sent directly to this office from each state listed.**

## IV. Clinical & National Boards

Have you taken and passed the National Boards? ____________________________

<table>
<thead>
<tr>
<th>Dates—Part 1</th>
<th>Dates—Part II</th>
</tr>
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</table>

If not on file in the Board office, you must have National Board send your scores directly to the office.

Have you taken and passed a state or regional clinical board? If so, which one? ____________________________

<table>
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<tr>
<th>Location where you took the exam</th>
<th>Dates</th>
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If not on file in the Board office, you must have the testing agency forward your scores directly to the office.
Please respond to all questions. If you answer “yes” to any question, you must attach a written explanation. In addition, if you answer “yes” to any question, you may be requested to appear before the Board to answer additional questions and/or provide additional information.

Circle One

1. During any professional/dental education, were you ever dismissed, suspended, restricted, disciplined, placed on probation, or otherwise acted against or did you take a leave of absence?  
   Yes  No

2. During any professional/dental education, were you ever requested to leave or did you leave, temporarily or permanently, prior to completion of training?  
   Yes  No

3. Have you ever had an application for a license/certificate in any health care profession refused or denied by any licensing board, regulatory agency, health care facility or other entity?  
   Yes  No

4. Have you ever had any written complaint, formal accusation, final order, disciplinary action, malpractice or consent order filed against you by any person, jurisdiction, licensing board or regulatory agency?  
   Yes  No

5. Have you ever been arrested, charged or convicted, pled guilty or pled nolo contendere for violation of any federal, state, or local law (other than a minor traffic violation)?  
   Yes  No
   (DWI & DUIs are not minor traffic violations).  
   (Although a conviction may have been expunged from the records by order of the court, it nevertheless must be disclosed in your answer).  
   You must attach the court disposition.

6. Are you currently under investigation or the subject of pending disciplinary action by any licensing board, regulatory agency, health care facility or other entity?  
   Yes  No

7. Currently or within the last five years, have you been treated for any physical, mental or emotional condition that might interfere with your ability to competently and safely perform the essential functions of practice?  
   Yes  No

8. Currently or within the last five years, have you been treated for drug or alcohol addiction that might interfere with your ability to competently and safely perform the essential functions of practice?  
   Yes  No

9. Currently or within the last five years, have you developed any disease or condition, physical, mental or emotional, that might interfere with your ability to competently and safely perform the essential functions of practice?  
   Yes  No

I belong to the following professional societies and organizations:
__________________________________________________________________________________________________
__________________________________________________________________________________________________

If I am licensed in West Virginia, I plan to (open my own office, intern at _________________________, enter the armed forces, joined Dr. __________________, etc.): ___________________________________________________
in __________________________ in West Virginia starting _________________.

Have you ever been known by any name(s) other than what is listed above? _______ Yes _______ No.

If yes, state in full every other name by which you have been known. If change was made by a Court Order, enclose copy.
__________________________________________________________________________________________________
__________________________________________________________________________________________________
__________________________________________________________________________________________________
Physician’s Statement of Examination of Applicant

I, ____________________________________, a duly licensed physician of the State of _____________________, have this day examined ______________________________________. The applicant herein, and my medical examination reveals that such applicant is free from all infectious, malignant, and contagious diseases, and such applicant is in sound and good health. Examination made in ______________________________________________________, State of _________________________, on the ________________day of __________________, 20____.

_____________________________________________, MD/DO

Physician’s Signature

VI. References

List below the names of two individuals supplying references of good moral character from persons who know you professionally. May not come from family members. Reference letters are to be sent directly to the Board by fax or U. S. Mail.

<table>
<thead>
<tr>
<th>Name</th>
<th>Address</th>
<th>Occupation</th>
</tr>
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<tbody>
<tr>
<td>1.</td>
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<tr>
<td>2.</td>
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In addition to the foregoing information, I add the following:

1. I will read the Dental Laws and Rules of West Virginia before appearing before the Board for a jurisprudence examination, and I intend to practice dentistry in keeping within the spirit and the letter of these laws.

2. I hereby give permission to the West Virginia Board of Dentistry to secure additional information concerning me or any of the statements in this application from any person or any source the Board may deem necessary. I release, discharge and exonerate the Board, or its agents, and/or any person furnishing information about me from any and all liability of every nature and kind arising out of the furnishing of such information.

3. I further agree to submit to questioning by the Board or any member thereof, and to substantiate my statements when necessary.

4. I shall present all credentials and documents required or requested by the Board.

5. I, the undersigned, do hereby affirm under penalty of perjury that all statements made and information contained in this application are true and correct to the best of my knowledge and belief. Further, I consent to a thorough investigation of my employment record and other information that may be necessary to verify my qualifications to practice. I understand that any final disciplinary actions that may ever be taken against my license, if granted, would be provided to a national disciplinary reporting system and that my Social Security number would be a part of that report.

This is to certify that the foregoing information is true and correct to the best of my knowledge.

________________________________________________________________________

Signature of Applicant

Date

________________________________________________________________________

NOTARY

(PHOTOGRAPH)

ATTACH A RECENT PHOTOGRAPH HERE

Name of Applicant

County of _________________ State of ________________

Being duly sworn, says that he/she is the person who executed the above application for license to practice dentistry in the State of West Virginia, and that all the statements herein contained are true in every respect and that the attached photo is a true photo of the applicant.

________________________________________________________________________

Notary Signature

Sworn to and subscribed before me this _____ day of ________, 20____.

My Commission Expires _____________________________

NOTARY: Do not notarize unless a photograph is attached.

(MEASUREMENTS)