APPLICATION FOR SPECIAL VOLUNTEER DENTAL HYGIENE LICENSE

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 ________________________

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:  ______________________________________

*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.

Military Service: __________________________________  Dates of 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. The application form is a public document subject to the Freedom of Information Act.
### II. Education Information

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

<table>
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<tr>
<th>Name of School</th>
<th>Location (City, State or)</th>
<th>From (Month/Year)</th>
<th>To (Month/Year)</th>
<th>Graduated Yes/No</th>
<th>Degree</th>
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<td>Pre-Dental</td>
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<td>Dental Hygiene</td>
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### 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>
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<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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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.

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

2. During any professional/dental hygiene 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 & DUI's are not minor traffic violations).  
   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

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.

______________________________________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________

I plan to volunteer at ____________________. I have attached the written agreement, as required by law, §30-4-8a, with the clinic and their proof of insurance.
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

V. References

List below the names of two individuals (preferably dentists) supplying references of good moral character, neither of whom is related to you or is a teacher at any dental college you attended. 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>
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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 and intend to practice dentistry in keeping within the spirit and the letter of these laws.

2. My special volunteer dentist license will be exclusively devoted to providing dentistry or dental hygiene care to needy and indigent persons in West Virginia; I will not receive any payment or compensation, either direct or indirect, or have the expectation of any payment or compensation, for any dentistry services rendered under the special volunteer dentist license.

3. I will supply any supporting documentation that the board may reasonably require.

4. I agree to continue to participate in continuing professional education as required by the board for the special volunteer dentist.

5. 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.

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

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

8. 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.

I certify that the foregoing information is true and correct to the best of my knowledge. I understand filing of false information may subject my license to disciplinary action including, but not limited to, revocation or suspension of my license.
You must supply a copy of the written agreement with the clinic and a statement that the clinic will be providing the malpractice insurance which is required by the new law, a copy of which is attached.

Please supply a copy of the following:

- Copy of current Drivers license;
- Copy of current CPR card; and
- Copy of recent infection control continuing education certificates.

If not a US citizen, please provide a copy of the following:

- Copy of US Immigration Services work authorization or permit.