PENNSYLVANIA STATE BOARD OF DENTISTRY
P.O. BOX 2649
HARRISBURG, PA 17105-2649

APPLICATION FOR A TEMPORARY VOLUNTEER LICENSE TO PRACTICE DENTISTRY

Instructions and Application Form

Introduction:

Please read the following instructions in their entirety. These instructions will assist in the application process for a Pennsylvania temporary volunteer dental license. The checklist format will assist you in requesting and submitting the appropriate documentation necessary to meet the licensure requirements.

There are two methods by which you may apply for your Pennsylvania TEMPORARY dental license which allows out-of-state dentists who are actively licensed to practice dentistry in another state to volunteer their services at events held in Pennsylvania without personal remuneration. The Board may issue one of the following:

1) No more than one 30-day temporary volunteer dental license per applicant per calendar year.
2) No more than three 10-day temporary volunteer dental license per applicant per calendar year.

***Note: The application request should be submitted to the Board office at least **60** days prior to the requested event (start) date.

Instructions Checklist

The following documents are required for a temporary volunteer dental license:

A. ☐ **Application Forms – Pages 1, 2, 3 and 4**

Page 1 – Applicant Information

Verification of Name:

If any document required for licensure is in a name **other** than the name under which you applied, a photocopy of the appropriate name change document must be attached. The only documents accepted by the Board are a marriage certificate, a divorce decree that reflects the retaking of a maiden name, or court issued legal name change document.

Page 1 – Current or Previous Licensure History

List each state, territory, or country where you have ever held a license to practice dentistry whether the license(s) is active or inactive, current or expired.

Page 2 – Personal History Information

If you respond **"YES"** to any of the personal history questions, you must submit the following:

- A written letter of explanation must be submitted to the Board outlining the details of the "YES" response(s).
- Certified copies of the record relating to the action taken. It is your responsibility to request and submit certified copies of court documents directly to the Board office. If you have been disciplined by another state licensing board, certified copies of the disciplinary record must be submitted directly to the Board office in a sealed official state board envelope.

Page 2 - Verification Statement

Please read the verification statement in its entirety, sign and date.

B. ☐ Event Information – Page 3

Complete page 3 in its entirety providing all pertinent information relating to the event in which you will be participating and volunteering your services without personal remuneration. The form must be signed, dated and returned to the Board office.

Also, you must attach a copy of the announcement or a letter from the event provider that includes the event information, dates, location, etc.

C. ☐ Certification of Proof of Professional Liability Insurance – Page 4

Complete the Certification Statement by certifying that you have obtained professional liability insurance or that you are a named insured covered by a group policy with a minimum amount of $1,000,000 per occurrence and $3,000,000 per annual aggregate. Additionally, you must also attach either a copy of the insurance issued by the insurer or a copy of the declaration page of the professional liability insurance policy.

D. ☐ Verification of Licensure

Request a letter of good standing from each state or jurisdiction where you have ever held a license, certificate, permit, registration or other authorization to practice any profession or occupation whether active or inactive, current or expired. The letter(s) of good standing must contain the proper signature, date and seal of the licensing authority and must be sent **directly** to the Pennsylvania State Board of Dentistry in a sealed official envelope of the state licensing board.

Note: If you have been disciplined by a state licensing board, the letter of good standing must include certified copies of the disciplinary record.

E. ☐ National Practitioner Data Bank / Healthcare Integrity and Protection Data Bank

You must obtain a Self-Query through the National Practitioner Data Bank / Healthcare Integrity and Protection Data Bank. To request a self-query, go to www.npdb-hipdb.hrsa.gov.

Once the report is completed and available, you must print the report from the above-listed website and submit directly to the Board office.

F. ☐ **Board Office**

Mail pages 1, 2, 3 and 4 of your application along with your professional liability documentation and a copy of your name change document, if applicable, directly to the Board office:

Mailing Address
PA Dept of State, Bureau of Professional and Occupational Affairs
Attn: State Board of Dentistry P.O. Box 2649 Harrisburg, PA 17105-2649

Street Address (Courier Delivery)
PA Dept of State, Bureau of Professional and Occupational Affairs
Attn: State Board of Dentistry
2 Technology Park
Harrisburg, PA 17110-2919

IMPORTANT INFORMATION

- The Board's application forms must be submitted in their original format and may not be altered. Altered forms will be rejected and cause further delay in the processing of your application.
- Once your application has been processed, you may check on the status of your application and/or issuance of your license through the Board's website at www.mylicense.state.pa.us.
- Should the application not be completed within six months, updated documentation may be required.

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P.O. BOX 2649
HARRISBURG, PA 17105-2649

Telephone: 717-783-7162
Facsimile: 717-787-7769
Website: www.dos.pa.gov/dent
Email: st-dentistry@pa.gov

APPLICATION FOR A TEMPORARY VOLUNTEER LICENSE TO PRACTICE DENTISTRY

METHOD OF APPLICATION

Please check one of the following: ☐ 30-day (Limit 1 per calendar year) ☐ 10-day (Limit 3 per calendar year)

APPLICANT INFORMATION

EMAIL ADDRESS:_____

NAME: _____
LAST FIRST MIDDLE

ADDRESS: _____
STREET

_____
CITY STATE ZIP CODE

U.S. Social Security Number: – – *ETIN or SIN cannot be accepted.

Date of Birth: – – Telephone Number: ( ) –

If any document required for the temporary license is in a **name other than above**, please indicate the name(s). A copy of the appropriate name change document must be attached. _____

CURRENT OR PREVIOUS LICENSURE HISTORY

Please list all states, territories and countries where you hold/held a license to practice dentistry. (This includes active or inactive, current or expired.) You will need to request a letter of good standing from each state or territory to be submitted directly to the Board office in a sealed official envelope of the licensing authority.

State or Jurisdiction	Active or Inactive	License Obtained by: Examination	Other

CONTINUING EDUCATION CERTIFICATION

	Yes	No
Are you current on all continuing education requirements in the state(s) where you are actively licensed to practice dentistry?	☐	☐

PERSONAL HISTORY INFORMATION

Please check Yes or No to each of the following questions:	YES	NO
1) Have you had disciplinary action taken against a professional or occupational license, certificate, permit, registration or other authorization to practice a profession or occupation issued to you in any state or jurisdiction or have you agreed to voluntary surrender in lieu of discipline?	☐	☐
2) Do you currently have any disciplinary charges pending against your professional or occupational license, certificate, permit or registration in any state or jurisdiction?	☐	☐
3) Have you withdrawn an application for a professional or occupational license, certificate, permit or registration, had an application denied or refused, or for disciplinary reasons agreed not to apply or reapply for a professional or occupational license, certificate, permit or registration in any state or jurisdiction?	☐	☐
4) Have you been convicted (found guilty or pleaded guilty or entered a plea of nolo contendere), received probation without verdict or accelerated rehabilitative disposition (ARD), as to any criminal charges, felony or misdemeanor, including any drug law violations? Note: You are not required to disclose any ARD or other criminal matter that has been expunged by order of a court.	☐	☐
5) Do you currently have any criminal charges pending and unresolved in any state or jurisdiction?	☐	☐
6) Have you had your DEA registration denied, revoked suspended or restricted or have you had your provider privileges terminated by any medical assistance agency for cause?	☐	☐
7) Have you ever had provider privileges denied, revoked, suspended or restricted by a Medical Assistance agency, Medicare, third party payor or another authority?	☐	☐
8) Have you ever had practice privileges denied, revoked, suspended or restricted by a hospital or any health care facility?	☐	☐
9) Have you ever been charged by a hospital, university, or research facility with violating research protocols, falsifying research, or engaging in other research misconduct?	☐	☐
10) To your knowledge, are you currently the subject of a disciplinary investigation?	☐	☐
11) Do you currently engage in, or have you ever engaged in, the intemperate or habitual use or abuse of alcohol or narcotics, hallucinogenics or other drugs or substances that may impair judgment or coordination?	☐	☐

VERIFICATION STATEMENT

By signing below, I verify that this form is in the original format as supplied by the Department of State and has not been altered or otherwise modified in any way. I am aware of the criminal penalties for tampering with public records or information pursuant to 18 Pa. C.S.§4911.

Additionally, I verify that the statements in this application are true and correct to the best of my knowledge, information and belief, and that I am of good moral character. I understand that any false statement made is subject to the penalties of 18 Pa. C.S.§4904 relating to unsworn falsification to authorities and may result in the suspension, revocation or denial of my license, certificate, permit or registration.

Signature of Applicant: _____ Date: _____

STATE BOARD OF DENTISTRY
P.O. BOX 2649
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APPLICATION FOR A TEMPORARY VOLUNTEER
TO PRACTICE DENTISTRY

APPLICANT INFORMATION

NAME: _____
LAST FIRST MIDDLE

ADDRESS: _____
STREET

_____
CITY STATE ZIP CODE

EVENT INFORMATION

Please <u>check</u> one: ☐ 30-day temporary volunteer dental license **(No more than 1 may be issued in a calendar year)** ☐ 10-day temporary volunteer dental license **(No more than 3 may be issued in a calendar year)**

Name of Sponsoring Organization: _____

Address of Sponsoring Organization: _____

_____

Location of the Event: _____

Event Date(s): _____

I certify that _____ will be volunteering my services in the practice of dentistry for
Name of Applicant

the above-listed event without personal remuneration.

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Signature of Applicant: _____ Date: _____

*****Applications should be submitted a minimum of 60-days prior to the event date(s) to allow for processing.*****

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CERTIFICATION OF PROOF OF PROFESSIONAL LIABILITY INSURANCE

CERTIFICATION STATEMENT

I hereby certify that (check one):

☐ I have professional liability insurance

_____

Insurer Name and Policy Number

OR

☐ I am a Named Insured covered by a group policy

_____

Insurer Name and Policy Number

in the minimum amount of $1,000,000 per occurrence and $3,000,000 per annual aggregate.

I have included a copy of (check one):

☐ A certificate of insurance issued by the insurer

OR

☐ A copy of the declarations page of the professional liability insurance policy.

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Signature of Applicant: _____ Date: _____