Application for Limited Licensure Dentist/Dental Hygienist

Board of Dentistry
P.O. Box 6330
Tallahassee, FL 32314-6330
Website: www.floridasdentistry.gov
Email: info@floridasdentistry.gov
Phone: (850) 245-4474
FAX: (850) 921-5389

Florida HEALTH
Medical Quality Assurance

Are you an active duty member of the United States Armed Services?

Are you a veteran of the United States Armed Services?

Are you the spouse of a veteran of the United States Armed Services?

Are you the spouse of an active member of the United States Armed Services?

If you answered “Yes” to any of these questions, you may qualify for a reduction in your application fees. You can find information about the Florida Department of Health’s commitment to serving members and veterans of the United States Armed Forces and their families online at

http://www.flhealthsource.gov/valor

Florida HEALTH
Medical Quality Assurance

Limited License Information

The limited licensee may only practice in the employ of public agencies or non-profit agencies or institutions which meet the requirements of section (s.) 501(c)(3) of the Internal Revenue Code that are permitted under Rule 64B5-7.006, Florida Administrative Code (F.A.C.) and which provide professional liability coverage for acts or omissions of the limited licensee. Limited licensees may provide services only to the indigent or critical need populations within the state.

To qualify for Florida limited licensure, the applicant must have:

Retired or intend to retire from the practice of dentistry/dental hygiene and intend to practice only pursuant to the restrictions of the limited license.

AND

Been licensed to practice dentistry/dental hygiene in any United States jurisdiction for at least ten years.

Application for Limited Licensure
Dentist/Dental Hygienist

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Do Not Write in this Space
For Revenue Receipting Only

Applicants are encouraged to review section (s.) 456.015, Florida Statutes (F.S.), and Rule Chapter (ch.) 64B5-7.007, Florida Administrative Code (F.A.C.) prior to submitting your application.

Select one option based on your practice setting:

- ☐ **Non-Remunerated** (Volunteer, not paid for services)- **No Fee**
- ☐ **Remunerated** (Paid employee)
  - ☐ **Dentist** (701)- **$305.00**
  - ☐ **Dental Hygienist** (702)- **$85.00**

Total fee includes the following:

Dentist

Application Fee (non-refundable)	$300.00
Unlicensed Activity Fee	$5.00

Dental Hygienist

Application Fee (non-refundable)	$80.00
Unlicensed Activity Fee	$5.00

Fees must be paid in the form of a cashier's check or money order, made payable to the Department of Health.

1. PERSONAL INFORMATION

Name: _____ **Date of Birth:** _____
Last/Surname First Middle MM/DD/YYYY

Mailing Address: (The address where mail and your license should be sent)

_____ _____ _____
Street/P.O. Box Apt. No. City

_____ _____ _____ _____
State ZIP Country Home/Cell Telephone (Input without dashes)

Physical Location: (Required if mailing address is a P.O. Box- This address will be posted on the Department of Health's website)

_____ _____ _____
Street Suite No. City

_____ _____ _____ _____
State ZIP Country Work/Cell Telephone (Input without dashes)

EQUAL OPPORTUNITY DATA:

We are required to ask that you furnish the following information as part of your voluntary compliance with 41 CFR Part 60-3-Uniform Guidelines on Employee Selection Procedure (1978); 43 FR 38295 and 38296 (August 25, 1978). This information is gathered for statistical and reporting purposes only and does not in any way affect your candidacy for licensure.

Gender: ☐ Male ☐ Female

Race: ☐ Native Hawaiian or Pacific Islander ☐ American Indian or Alaska Native ☐ Two or More Races ☐ Hispanic or Latino ☐ Black or African American ☐ White ☐ Asian

Email Notification: To be notified of the status of your application by email, check the "Yes" box and fill in your email address on the line provided. If you choose to be notified via email you will be responsible for checking your email regularly and updating your email address with the board office.

☐ Yes ☐ No Email Address: _____

Under Florida law, email addresses are public records. If you do not want your email address released in response to a public records request, do not provide an email address or send electronic mail to our office. Instead contact the office by phone or in writing.

2. SOCIAL SECURITY DISCLOSURE

This information is exempt from public records disclosure.

Last Name: _____

First Name: _____

Middle Name: _____

Social Security Number: _____
(Input without dashes)

Pursuant to Title 42 United States Code § 666(a)(13), the department is required and authorized to collect Social Security numbers relating to applications for professional licensure. Additionally, s. 456.013(1)(a), Florida Statutes (F.S.) authorizes the collection of Social Security numbers as part of the general licensing provisions.

Name: _____

3. APPLICANT BACKGROUND

A. Have you ever changed your name through marriage or through action of a court, or have you ever been known by any other name? ☐ Yes ☐ No

If "Yes," list name(s) and date(s) of change(s):

_____

B. Do you hold, or have you ever held a license to practice dentistry, dental hygiene, in any state, U.S. territory, or foreign country? ☐ Yes ☐ No

C. List all dentistry licenses (active, inactive or lapsed), starting with the most recent.

License Type	License #	State/Country	Original Date Issued (MM/DD/YYYY)	Expiration Date (MM/DD/YYYY)	Status of License

☐ **Submit a License Verification** form to **ALL** state(s) of licensure. License verifications must be received directly from the licensing authority regardless of the status of the license. **A copy of your license will not be accepted** in lieu of official verification from the licensing agency. If the state has an online verification **including disciplinary actions,** the board office will accept the online verification.

D. Have you practiced dentistry/dental hygiene as a licensed dentist/dental hygienist for at least ten years in the United States? ☐ Yes ☐ No

E. Have you retired or intend to retire from the practice of dentistry/dental hygiene? ☐ Yes ☐ No

If you responded "Yes," provide the retirement/intended retirement date: _____.
MM/DD/YYYY

F. Do you state that you will practice only as a specified in Rule 64B5-7.007, F.A.C., if granted a Florida limited license? ☐ Yes ☐ No

G. List the place you intend to practice in Florida.

Employment Setting: ☐ Public or Non-profit Agency ☐ Indigent or Critical Need Population in Florida	
Place of Employment:	
Employment Address:	

☐ The director of the agency or institution must submit a letter of intention to employ.

Section 456.015, F.S., requires that within 30 days of any change of employment, the department must be notified of the new address and place of employment.

H. Are you registered with the Drug Enforcement Administration (DEA) to prescribe controlled substances? ☐ Yes ☐ No

If "Yes," provide your DEA number: _____

Name: _____

4. EDUCATION HISTORY

List all dental school(s) attended.

Dental School Name/Address	Graduation Date (MM/DD/YYYY)
Degree Awarded	
☐ DDS ☐ DMD ☐ AS ☐ Other: _____	

All applicants must attach:

☐ **A copy of their dental diploma**

☐ **Proof of current CPR certification**

Have you received training and hold current certification from the American Heart Association, the American Red Cross, or entity with equivalent requirements in cardiopulmonary resuscitation (CPR) at the basic support level, including one-rescuer and two-rescuer CPR for adults, children, and infants; the use of an automatic external defibrillator (AED); and the use of ambu-bags? ☐ Yes ☐ No

☐ American Heart Association	Certification #:
☐ American Red Cross	Issue Date (MM/DD/YYYY):
☐ Other: _____	Expiration Date (MM/DD/YYYY):

Submit all supporting documentation not included with the application to the board office at:

Board *of* Dentistry
4052 Bald Cypress Way Bin C-04
Tallahassee, FL 32399-3258

Name: _____

This information is exempt from public records disclosure.

5. HEALTH HISTORY

Physical and Mental Health Disorders Impacting Ability to Practice

A. During the last two years, have you been treated for or had a recurrence of a diagnosed physical or mental disorder that impaired or would impair your ability to practice? ☐ Yes ☐ No

B. In the last two years, have you been admitted or referred to a hospital, facility or impaired practitioner program for treatment of a diagnosed mental or physical disorder that impaired your ability to practice? ☐ Yes ☐ No

Substance-Related Disorders Impacting Ability to Practice

C. During the last five years, have you been treated for or had a recurrence of a diagnosed substance-related (alcohol or drug) disorder that impaired or would impair your ability to practice? ☐ Yes ☐ No

D. During the last five years, were you admitted or directed into a program for the treatment of a diagnosed substance-related (alcohol or drug) disorder or, if you were previously in such a program, did you suffer a relapse? ☐ Yes ☐ No

E. During the last five years, have you been enrolled in, required to enter, or participated in any substance-related (alcohol or drug) recovery program or impaired practitioner program for treatment of drug or alcohol abuse? ☐ Yes ☐ No

If a "Yes" response was provided to any of the questions in this section, provide the following documents directly to the board office:

☐ **A letter from a Licensed Health Care Practitioner,** who is qualified by skill and training to address the condition identified, which explains the impact the condition may have on the ability to practice the profession with reasonable skill and safety. The letter must specify that the applicant is safe to practice the profession without restrictions or specifically indicate the restrictions that are necessary. Documentation provided must be dated within one year of the application date.

☐ **A written self-explanation,** identifying the medical condition(s) or occurrence(s); and current status

Name: _____

6. DISCIPLINE HISTORY

A. Have you ever been denied the right to take a dentistry or dental hygiene examination in any state?
☐ Yes ☐ No

B. Have you ever been refused a license to practice dentistry, dental hygiene, or any other license, or the renewal thereof in any state? ☐ Yes ☐ No

C. Have you ever had a license or a certificate of registration to practice dentistry, dental hygiene, or any other licensed profession revoked, suspended or otherwise acted against (including probation, fine or reprimand) in a disciplinary proceeding in any state? ☐ Yes ☐ No

D. Are you now or have you ever been a defendant in civil litigation in which the basis of the complaint against you was alleged negligence, malpractice, or lack of professional competence? ☐ Yes ☐ No

E. Do you have a pending complaint in any jurisdiction against your professional conduct or competence as a dentist or dental hygienist? ☐ Yes ☐ No

If you responded "Yes" to any of the questions in this section, complete the following:

Name of Agency	State	Action Date (MM/DD/YYYY)	Final Action	Under Appeal?
				☐ Y ☐ N
				☐ Y ☐ N
				☐ Y ☐ N
				☐ Y ☐ N

If you responded "Yes" to any of the questions in this section, you must provide the following:

☐ **A written self-explanation**, describing in detail the circumstances surrounding the disciplinary action.

☐ A copy of the **Administrative Complaint** and **Final Order**.

7. CRIMINAL HISTORY

Have you ever been convicted of, or entered a plea of guilty, nolo contendere, or no contest to any crime in any jurisdiction other than a minor traffic offense? You must include all misdemeanors and felonies, even if adjudication was withheld. Pursuant to s. 943.0585(6)(b), F.S., and s. 943.059(6)(b), F.S., an applicant seeking to be licensed by the Department of Health must disclose expunged and sealed criminal history records.

Reckless driving, driving while license suspended or revoked (DWSLR), driving under the influence (DUI) or driving while impaired (DWI) are not minor traffic offenses for purposes of this question. ☐ Yes ☐ No

If you responded "Yes," complete the following:

Offense	Jurisdiction	Date (MM/DD/YYYY)	Final Disposition	Under Appeal?
				☐ Y ☐ N
				☐ Y ☐ N
				☐ Y ☐ N

If you responded "Yes" in this section, you must provide the following:

☐ **A written self-explanation**, describing in detail the circumstances surrounding each offense; including dates, city and state, charges and final results.

☐ **Final Dispositions** and **Arrest Records** for all offenses. The Clerk of the Court in the arresting jurisdiction will provide you with these documents. Unavailability of these documents must come in the form of a letter from the Clerk of the Court.

☐ **Completion of Sentence Documents**. You may obtain documents from the Department of Corrections. The report must include the start date, end date, and that the conditions were met.

Name: _____

8. CRIMINAL AND MEDICAID/MEDICARE FRAUD QUESTIONS

IMPORTANT NOTICE: Applicants for licensure, certification, or registration and candidates for examination may be excluded from licensure, certification, or registration if their felony convictions fall into certain timeframes as established in s. 456.0635(2), F.S.

1. Have you been convicted of, or entered a plea of guilty or nolo contendere, regardless of adjudication, to a felony under chapter (ch.) 409, F.S. (relating to social and economic assistance), ch. 817, F.S. (relating to fraudulent practices), ch. 893, F.S. (relating to drug abuse prevention and control), or a similar felony offense(s) in another state or jurisdiction? ☐ Yes ☐ No

   If you responded "No" to the question above, skip to question 2.

   a. If "Yes" to 1, for the felonies of the first or second degree, has it been more than 15 years from the date of the plea, sentence, and completion of any subsequent probation? ☐ Yes ☐ No

   b. If "Yes" to 1, for the felonies of the third degree, has it been more than ten years from the date of the plea, sentence, and completion of subsequent probation (this question does not apply to felonies of the third degree under s. 893.13(6)(a), F.S.)? ☐ Yes ☐ No

   c. If "Yes" to 1, for the felonies of the third degree under s. 893.13(6)(a), F.S., has it been more than five years from the date of the plea, sentence, and completion of any subsequent probation? ☐ Yes ☐ No

   d. If "Yes" to 1, have you successfully completed a drug court program that resulted in the plea for the felony offense being withdrawn or the charges dismissed (If "Yes," provide supporting documentation)? ☐ Yes ☐ No

2. Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, to a felony under 21 U.S.C. ss. 801-970 (relating to controlled substances) or 42 U.S.C. ss. 1395-1396 (relating to public health, welfare, Medicare and Medicaid issues)? ☐ Yes ☐ No

   If you responded "No" to the question above, skip to question 3.

   a. If "Yes" to 2, has it been more than 15 years before the date of application since the sentence and any subsequent period of probation for such conviction or plea ended? ☐ Yes ☐ No

3. Have you ever been terminated for cause from the Florida Medicaid Program pursuant to s. 409.913, F.S.? ☐ Yes ☐ No

   If you responded "No" to the question above, skip to question 4.

   a. If you have been terminated but reinstated, have you been in good standing with the Florida Medicaid Program for the most recent five years? ☐ Yes ☐ No

4. Have you ever been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid program? ☐ Yes ☐ No

   If you responded "No" to the question above, skip to question 5.

   a. Have you been in good standing with a state Medicaid program for the most recent five years? ☐ Yes ☐ No

   b. Did termination occur at least 20 years before the date of this application? ☐ Yes ☐ No

5. Are you currently listed on the United States Department of Health and Human Services' Office of the Inspector General's List of Excluded Individuals and Entities (LEIE)? ☐ Yes ☐ No

   a. If you responded "Yes" to the question above, are you listed because you defaulted or are delinquent on a student loan? ☐ Yes ☐ No

   b. If you responded "Yes" to question 5.a., is the student loan default or delinquency the only reason you are listed on the LEIE? ☐ Yes ☐ No

If you responded "Yes" to any of the questions in this section, you must provide the following:

☐ **A written self-explanation** for each question including the county and state of each termination or conviction, date of each termination or conviction, and copies of supporting documentation.

☐ **Supporting documentation** including court dispositions or agency orders where applicable.

Documents in sections 5, 6, 7, and 8 must be mailed to:

Board *of* Dentistry
4052 Bald Cypress Way Bin C-04
Tallahassee, FL 32399-3258

9. APPLICATION AFFIDAVIT/VERIFICATION OF DOCUMENT

I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past and present), business and professional associates (past and present), and all governmental agencies and instrumentalities (local, state, federal and foreign) to release to the Florida Department of Health any information, files, or records requested by the agency in connection with the processing of this application. I further authorize the Florida Department of Health to release to any organization, individual or group listed above any information which is material to my application.

I understand that it is my responsibility to supplement my application as needed to reflect any material changes in any circumstance or condition stated in the application which might affect the decision of the department and which takes place between the initial filing of the application and the final granting or denial of limited licensure.

I hereby affirm that I have been licensed to practice the profession for which I now seek a limited license in a jurisdiction of the United States for at least 10 years. I affirm that I have retired from the practice of that profession and intend to practice only pursuant to the restrictions of the limited license. I understand that, once my limited license is granted, I may only practice in the employ of public agencies or institutions or nonprofit agencies or institutions which meet the requirements of s. 501(c)(3) of the Internal Revenue Code, and which provide professional liability coverage for my acts or omissions as the limited licensee. I also understand that, as a limited licensee, I may provide services only to the indigent or critical need populations within the state.

I have carefully read the instructions and questions in the foregoing application and have answered them completely, without reservations of any kind. Should I furnish any false information in this application, or in any supporting documentation, I acknowledge that such an act constitutes cause for denial, disciplinary action, suspension or revocation of my limited license to practice dentistry under Chapter 466, Florida Statutes, Chapter 456, Florida Statutes, and Chapter 64B5, Florida Administrative Code, in the State of Florida.

I hereby affirm that I have received, read and understood Chapter 466, Florida Statutes, Chapter 456, Florida Statutes, and Chapter 64B5, Florida Administrative Code, and acknowledge that I must abide by them.

Under penalties of perjury, I declare that I have read the foregoing Limited Licensure Application and that the facts stated in it are true.

Applicant Signature _____ Date _____
You may print this application and sign it or sign digitally. MM/DD/YYYY

Board *of* Dentistry
Financial Responsibility

This form is required for Dentists only.

Name: _____

The Financial Responsibility options are divided into two categories: coverage and exemptions. **Choose only ONE** option that best describes your situation, unless you choose **option 3** in the **"Financial Responsibility Coverage"** section. If you provided financial responsibility information to a hospital or elsewhere, be consistent when choosing.

Be advised, failing to choose an option or choosing more than one option will make this form invalid and will delay your licensure. Department staff is unable to advise you on which option to choose. If you have questions regarding an option, consult your personal legal counsel, insurance company or financial institution for advice.

FINANCIAL RESPONSIBILITY COVERAGE

☐ 1. I have obtained and will maintain professional liability coverage in an amount of not less than $100,000, with a minimum annual aggregate of not less than $300,000, from an authorized insurer as defined under s. 624.09, F.S., from a surplus lines insurer as defined under s. 626.914(2), F.S., from a risk retention group as defined under s. 627.942, F.S., from the Joint Underwriting Association established under s. 627.351(4), F.S., or through a plan of self-insurance as provided in s. 627.357, F.S.

☐ 2. I have obtained and will maintain an unexpired irrevocable letter of credit as defined in ch. 675, F.S., in an amount no less than $100,000 per claim, with a minimum aggregate availability of credit not less than $300,000.

☐ 3. I am exempt from financial responsibility coverage ***(If you choose this option you must choose one option from the exemption category below.)***

EXEMPTION CATEGORIES OF FINANCIAL RESPONSIBILTY COVERAGE

☐ 1. I practice exclusively as an officer, employee, or agent of the federal government, or of the state or its agencies or subdivisions.

☐ 2. I practice only in conjunction with my teaching duties at an accredited school or in its main teaching hospitals.

☐ 3. I have no malpractice exposure because I do not practice in the state of Florida.

Section 456.067, F.S.: Penalty for giving false information - In addition to, or in lieu of, any other discipline imposed pursuant to s. 456.072, F.S., the act of knowingly giving false information in the course of applying for or obtaining a license for the department, or any board thereunder, with intent to mislead a public servant in the performance of his or her duties, or the act of attempting to obtain or obtaining a license from the department, or any board thereunder, to practice a profession by knowingly misleading statements or knowing misrepresentations constitutes a felony of the third degree, punishable in s. 775.082, s. 775.083, or s. 775.08, F.S.

Applicant Signature: _____ Date: _____
MM/DD/YYYY

Board *of* Dentistry
4052 Bald Cypress Way Bin C-04
Tallahassee, FL 32399-3258

Board *of* Dentistry
Limited License Fee Waiver Form

To be completed by employer or volunteer dentist/ dental hygienist.

Pursuant to s. 456.015, F.S., and Rule 64B5-7.007, F.A.C., if a person applying for a limited license submits a notarized statement from the employing agency or institution stating that they will not receive monetary compensation for any services involving the practice of dentistry/dental hygiene, the licensure fees will be waived.

AFFIDAVIT

I, _____, being first duly sworn, state that the following dentist/dental hygienist

_____ will not receive monetary compensation for any service involving the
(Dentist/Dental Hygienist's Name)

practice of dentistry/dental hygiene from:

Agency/Institution: _____

Address: _____

City: _____ State: _____ ZIP: _____

Signed: _____ Name: _____

State of _____ County of _____

Sworn to and/or subscribed before me this _____ day of _____, 20_____

by _____

Personally Known _____ OR Produced Identification _____

Type of Identification Produced _____

Notary Signature _____ Printed Name of Notary _____

These signature fields cannot be typed. You must print the application and sign it before a notary public.

[NOTARY SEAL]