APPLICATION FOR REINSTATEMENT OF LICENSE TO PRACTICE DENTISTRY IN NORTH CAROLINA

TO: **North Carolina State Board of Dental Examiners**
2000 Perimeter Park Drive, Suite 160
Morrisville, NC 27560

I hereby make application for the reinstatement of my license to practice dentistry in the STATE OF NORTH CAROLINA, and submit the following information:

ORIGINAL NC LICENSE NUMBER:_____ **DATE OF ISSUANCE:** ____/____/____

FULL NAME: _____

PRESENT ADDRESS: _____

_____( )_____
(city) **(state)** **(zip)** **(Phone)**

EMAIL ADDRESS: _____

Have you ever:

a) been summoned to court or before a magistrate for the violation of any law or ordinance or for the commission of any felony or misdemeanor? ___Yes ___ No

b) been arrested for the violation of any law or ordinance or for the commission of any felony or misdemeanor? ___Yes ___ No

c) been taken into custody for the violation of any law or ordinance or for the commission of any felony or misdemeanor? ___Yes ___ No

d) been indicted for the violation of any law or ordinance or for the commission of any felony or misdemeanor? ___Yes ___ No

e) been convicted or tried for the violation of any law or ordinance or for the commission of any felony or misdemeanor? ___Yes ___ No

f) been charged with the violation of any law or ordinance or for the commission of any felony or misdemeanor? ___Yes ___ No

g) pleaded guilty to the violation of any law or ordinance or for the commission of any felony or misdemeanor? ___Yes ___ No

If your answer is yes to any of the foregoing questions, attach a statement describing fully the nature of any such matters, with complete facts, disposition of the matter, and the name and address of the authority in possession of the records thereof. Only traffic violations unrelated to alcohol or drugs may be excluded from this answer.

Are you currently or have you ever been investigated by this Board or any other Licensing Boards?
_____Yes _____No

Have you ever had a civil suit settled or a case entered into the National Practitioner Data Bank?
_____Yes _____No

Do you currently have any condition or impairment (including, but not limited to, substance abuse, alcohol abuse, or a mental, emotional, or nervous disorder or condition) that in any way affects your ability to practice dentistry in a competent, ethical, and professional manner? □ Yes □ No

If your answer to the previous question is yes, are the limitations caused by your condition or impairment reduced or ameliorated because you receive ongoing treatment or because you participate in a monitoring or support program? □ Yes □ No

If your answer to either of the previous questions is yes, complete the included provider summary and release forms for each service provider that has assessed or treated any such condition or impairment. Duplicate forms as needed. As used in the previous questions, "currently" means recently enough that the condition or impairment could reasonably affect your ability to function as a dentist.

List all other states/jurisdictions/territories in which you have ever been licensed: (Attach a separate sheet if necessary)

(CITY/STATE)	**(DATES)**

If you have been admitted to practice in any jurisdiction, provide the following certification on the next page and make a complete statement of all your practice since graduation to date. Include temporary or part-time work. Indicate:

1) The dates during which you were employed as a dentist or engaged in practice.
2) The addresses of the offices or places at which you were so employed or engaged, and the names and addresses of all employers, partners, associates, or persons sharing office space, if any (Attach sheet if necessary)
3) The nature of your practice. (General Dentistry or Specialty)
4) The reason for the termination of each employment or period of private practice.
5) **Be aware that a lapse in <u>practice</u>, not licensure, of 5 years or greater will result in a requirement to retake the clinical examination.**

FROM	**TO**	**NAME AND ADDRESS OF EMPLOYER/ASSOCIATES**	**NATURE OF PRACTICE**	**REASON FOR LEAVING**

To be used with Impairment Questions

DESCRIPTION OF CONDITION OR IMPAIRMENT FORM

Name _____

First *Middle* *Last* *Suffix*

Relevant dates: From Mo/Yr _____ To Mo/Yr _____

Describe the condition or impairment _____

Describe any treatment, or any program that includes monitoring or support _____

Name and complete address of attending physician or counselor (if applicable):

Name of physician or counselor _____

Physician's or counselor's current address _____

City _____ *StateZip* _____ *Country* _____

_____ *Province* _____

Telephone (___)_____

Name and complete address of hospital or institution (if applicable):

Name of hospital or institution _____

Hospital's or institution's current address _____

City _____ *StateZip* _____ *Country* _____

_____ *Province* _____

Telephone (___)_____

The Board of Dental Examiners of the State of North Carolina is aware of HIPAA requirements.

DO NOT ALTER THIS FORM
Corrections/erasures VOID this form
Please use black or blue ink

To be used with Impairment Questions

*Applicant's name*_____

*Name of institution, doctor, or counselor*_____

*Address*_____

*City*_____ *State*_____ *Zip*_____

*Country*_____ *Province*_____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION FORM

By signing below, I authorize the above provider to provide information, without limitation, relating to mental illness or the use of drugs and alcohol concerning advice, care, or treatment provided to me, to representatives of the Board of Dental Examiners of the State of North Carolina who are involved in conducting an investigation into my moral character, professional reputation, and fitness for the practice of law. I understand that any such information as may be received will be reported only to the admitting authority. The information will be used or disclosed at my request. This authorization will expire one year from the date of my notarized signature below. A photocopy of this form is acceptable for purposes of obtaining this information.

I hereby release, discharge, and exonerate the Board of Dental Examiners of the State of North Carolina, its agents and representatives, the admitting authority, its agents and representatives, and the above named provider, its agents and representatives so furnishing information from any and all liability of every nature and kind arising out of the furnishing or inspection of any documents, records, and other information, or out of the investigation made by the Board of Dental Examiners of the State of North Carolina or by the admitting authority.

I am not required to sign this authorization in order to receive treatment from the above provider. I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the provider has acted in reliance upon this authorization. My written revocation must be resubmitted to the Director of Investigations at the address of the provider above.

_____

Signature of Applicant *Date*

STATE/DISTRICT OF _____

COUNTY OF _____

Subscribed and sworn to or affirmed before me this _____day
of _____, _____
Month *Year*

_____

Signature of Notary

My commission expires _____

Seal or stamp must be affixed to each original.

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Revised 10/08/2021

I have attached:

- Two (2) letters of character reference (may not be from relatives)
- Certification from every state board for each state in which I am or have ever been licensed **other than NC** (must be provided by the state board office; copies of licenses or certificates are NOT acceptable)
- National Practitioner Data Bank Report [**Call (**800) 767-6732 if you are licensed in another state]
- Check in the amount of **$554.00** ($225.00 reinstatement fee, $289.00 renewal fee, $40.00 assessment for the Caring Dentist Program) The $225.00 reinstatement application fee is non-refundable.

  "If your check is not paid on presentment or is dishonored, you agree to pay the amount allowed by state law. We may electronically debit or draft your account for this charge. Also, if your check is returned for insufficient or uncollected funds, your check may be electronically re-presented for payment."
- Completed fingerprint cards and signed authorization for release of information Email your mailing address to info@ncdentalboard.org to receive a fingerprinting packet for out-of-state or Download release/info forms from and follow instructions on our website under the "LiveScan" tab for in-state)
- Documentation of 15 hours of CE in clinical patient care & current CPR certification

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I, _____, do solemnly swear that the above information is true and correct to the best of my knowledge and belief.

SIGNED:_____
(applicant)

Sworn to and subscribed before me this
_____ day of _____20____

_____ S E A L
NOTARY PUBLIC

My commission expires:_____