□ Application & Fee
□ Hospital Appointment
□ Dental Education
□ SS Addendum
□ CSR & Fee

FOR OFFICE USE ONLY

Receipt #_____
ID #_____
Issue Date_____
License #_____

RI DEPARTMENT OF HEALTH
Board of Examiners in Dentistry

Room 205
3 Capitol Hill
Providence, RI 02908-5097

Application and Instructions:

LIMITED DENTAL LICENSE

If applying for expedited military status, please complete the Military Expedition Form at the end of this application packet.

☐ **INTERN**

☐ **RESIDENT**

☐ **FELLOW**

Valid for One Year

Have you previously held a temporary license in RI?

☐ **Yes** ☐ **No**

Please Print Name Above

LIMITED DENTAL LICENSE

Name:_____
Prefix First Name Last Name Suffix

Social Security Number_____ **Date of Birth**_____

Home Address_____

Employment Address_____

Tel. Home_____ **Bus.Tel.**_____ **E-mail Address** _____

Professional/Medical Education (DDS, DMD)
Name of School_____

City/State/Country_____

Date Enrolled_____ **Date Graduated**_____ **Degree Received**_____

POST GRADUATE TRAINING

Program Name:_____

Address _____

Date Enrolled:_____ **Date Graduated**_____ **Credit Received □ yes □ no**

Specialty Area_____

EXAMINATION INFORMATION: List all exams taken(e.g.) National/Regional/Specialty Boards

_____

_____

DISCIPLINARY ACTIONS

Please answer all questions, If you answer "yes" to any of the questions, provide a detailed written explanation on a separate sheet of paper and submit with certified copies of supporting documents

1. **Have you ever been arrested and charged with a violation of, or pled Nolo Contendere to any Federal, State or Local statute, regulation or ordinance or entered into a plea agreement?**

2. **During any professional/medical education or postgraduate training, were you ever dismissed, suspended, restricted, put on probation or otherwise acted against or did you take a leave of absence for medical reasons?**

3. **During any professional/medical education or postgraduate training, were you ever requested to leave or did you leave, temporarily or permanently, prior to completion of training?**

4. **Are there any investigations pending against you?**

Limited Dental Application of: _____

AFFIDAVIT AND SIGNATURE

I, _____, being first duly sworn, depose and say that I am the person referred to in the foregoing application and supporting documents.

I hereby authorized all hospital(s), institutions, or organizations, my references, personal physicians, employers (past and present) and all governmental agencies and instrumentality's (local, state, federal or foreign) to release to the RI Board of Examiners in Dentistry any information which is material to my application for licensure.

I have read carefully the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for denial, suspension or revocation of my license to practice dentistry in the State of Rhode Island.

I understand that my records are protected under the Federal and State Regulations governing Mental Health Patient Records and cannot be disclosed without my written consent unless otherwise provided in the regulations. I understand that my records are protected under the Federal and State Regulations governing Confidentiality of Alcohol and drug Abuse Patient Records, 42CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided in the regulations.

I understand that this is a continuing application and that I have an affirmative duty to inform the Board of Examiners in Dentistry of any change in the answers to these questions after this application and affidavit is signed.

_____ _____

Signature of Applicant **Date of Signature**

The foregoing instrument was acknowledged before me this _____ day of _____,20___
Who is known to me or who has produced _____as identification and did/did not take an oath

_____ **My Commission Expires on:**_____

Signature of Notary

_____

Name of Notary Typed, Printed or Stamped

NOTARY SEAL

CERTIFICATION OF APPOINTMENT

To be completed by the Administrator or CEO of the facility in which the Applicant has received appointment.

This certifies that the applicant named below has been appointed to the designated position for the period indicated (one year):

First M. Last (Intern/Resident/Fellow)	**Position and Year**
Name of Facility	**Beginning Date Ending Date**

This institution was duly incorporated as a healthcare facility under the laws of the State of Rhode Island on:

Day	**Month**	**Year**

Original Signature of Facility Administrator	**Date of Signature**

Important: To be completed only for <u>First</u> temporary licensure in RI

CERTIFICATION BY DEAN OF DENTAL SCHOOL

This certifies that the Applicant named below has creditably completed not less that two years of clinical clerkship studies (last two years) in the designated school during the period indicated

Please print or type student's full name above	**Name of Dental School**
	Dental School City/State/Country

School Seal

Signature of Dean	**Date of Signature**

Rhode Island Department of Health

3 Capitol Hill, Providence RI, 02908-5097

MANDATORY ADDENDUM TO LICENSE APPLICATION

Tax Payer Status Affidavit / Identity Verification

All persons applying or renewing any license, registration, permit or other authority (herein after called "licensee") to conduct a business or occupation in the state of Rhode Island are required to file all applicable tax returns and pay all taxes owed to the state prior to receiving a license as mandated by state law (RIGL 5-76) except as noted below.
In order to verify that the state is not owed taxes, licensees are required to provide their Social Security Number, or Federal Tax Identification Number (for businesses) as appropriate. These numbers will be transmitted to the Division of Taxation to verify tax status prior to the issuance of a license.

Licensee Declaration

☐ I hereby declare, under penalty of perjury, that I have filed all required state tax returns and have paid all taxes owed.

☐ I have entered a written installment agreement to pay delinquent taxes that is satisfactory to the Tax Administrator.

☐ I am currently pursuing administrative review of taxes owed to the state.

☐ I am in federal bankruptcy. (Case # _____)

☐ I am in state receivership. (Case # _____)

☐ I have been discharged from Bankruptcy. (Case # _____)

_____
Type of Professional/Business License for which you are applying

_____ _____
Full Name (Please Print or Type) Social Security Number (or FEIN for Business)

_____ _____
Signature Phone Number (including area code if not 401)

_____ _____
Date Name of Business (If Applicable)

This form must be completed, signed and attached to your license application for processing.

Rhode Island Board of Examiners in Dentistry

Room 205, 3 Capitol Hill
Providence, RI 02908-5097
(401) 222-2827

Rhode Island Uniform Controlled Substances Act Registration (CSR)

I am applying for a Rhode Island Uniformed Controlled Substances Act Registration (CSR). **I understand that there is an additional $100.00 fee for this Registration and that the check or money order must be made out to the RI General Treasurer.**

Print/Type Full Name _____ Business Name _____ Limited RI DEN License No _____

Signature _____ Business Address _____ Business Telephone _____

. **Date** _____

Drug Schedule (Check all that apply)

Complete this application for registration to prescribe controlled substances in the State of Rhode Island

☐ **Schedule II** **Schedule III** **Schedule IV** **Schedule V**

A Copy of the DEA Registration must be provided to the Dental Board within 60Days of its issuance by the DEA. The DEA Registration must be issued to your Rhode Island Practice Address in order for it to be valid. If you are relocating from another state, you need to apply for a DEA Registration that is specific to Rhode Island. See The bottom of this form for information on how to contact DEA.*

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All Applicants MUST answer the following:

A. Has the applicant been convicted of, or entered a plea of nolo contendere to a violation of any state or federal law relating to manufacturing, distributing, possessing, prescribing, administering or dispensing of drugs presently defined as controlled substances under Chapter 21-28, General Laws of Rhode Island?

B. Has the registration application or registration of the applicant, corporation, firm, partner, or officer of the applicant been surrendered, revoked, suspended or denied under any law of the United States or of any state relating to drugs presently defined as controlled substances under Chapter 21-28 of the General Laws of Rhode Island, or is such action pending? **If you answered "Yes" to question "A" or "B" attach an explanation to this form.**

IMPORTANT INFORMATION

Issuance of a Rhode Island Controlled Substances Registration is contingent upon registration by the U.S. Drug Enforcement Administration. If denied a "DEA Registration",the Rhode Island Controlled Substances Registration becomes "**VOID**". Licensed drug facilities and licensed practitioners with prescriptive privileges, cannot dispense, possess, store or ship controlled substances in or into the State of Rhode Island without a valid drug facility or professional license. Rhode Island Controlled Substances Registration (CSR), and a federal Drug Enforcement Administration (DEA) Registration. Practitioners may only prescribe, dispense, possess, and store controlled substances within their particular "scope of practice". "Controlled Substances" for purposes of this application, means a prescription drug in Schedules II through V, pursuant to the Rhode Island Uniform Controlled Substances Act, and 21 CFR 1300 of the Federal Code of Regulations. Schedule I drugs are used by researchers, and require the submission of a protocol.
Without a Rhode Island CSR, and federal DEA Registration, licensed drug facilities, and practitioners with prescriptive privileges, may dispense or possess non-controlled prescription medications under its facility or professional license. A CSR will not be granted to an applicant whose BOARD licensure application is "pending" in this state.

A Rhode Island Controlled Substances Registration must be obtained prior to applying for the DEA Registration. Federal regulations require that applicants comply with individual state requirements prior to issuance of a DEA Registration. Once the CSR is issued, applicants must apply to the U.S. Drug Enforcement Administration for a federal registration using that agency's DEA Form 224 (New Application for Retail Pharmacy, Hospital/Clinic, Practitioner, Teaching Institution, or Mid-Level Practitioner).
Applicants may apply on-line for the DEA Registration at the following web site:
www.deadiversion.usdoj.gov./drugreg/reg_apps/index.html
*You can also receive an application, or check the status of a pending DEA Registration by contacting the Drug Enforcement Administration at the following location: Registration Unit, US Drug Enforcement Administration, JFK Federal Building, 15 New Sudbury Street, Boston, MA 02203-0131, Telephone (888) 272-5174.

NOTE:

- Schedules II, III, and IV of section 21-28-2.08 will become void unless dispensed within thirty (30) days of the original date of the prescription. - Prescriptions in schedules III, IV and V cannot be written for more that one hundred (100) dosage units and not more than one hundred (100) dosage units may be dispensed at one time. For purposes of this section, a dosage unit shall be defined as a single capsule, tablet or suppository, or not more than one (1) teaspoon of an oral liquid. - Prescriptions in schedule II may be written for up to a 30-day supply, with a maximum of two hundred and fifty (250) dosage units, as determined by the prescriber's directions for use of the medication.

INSTRUCTIONS

This application must be completed by the applicant only.

Please complete application in full and sign. Do not leave blanks, Mark "N/A" for any questions that are "Not Applicable". Incomplete forms will be returned to you and your license/permit will not be issued. Please type or print using a ball point pen.

A license fee of $65.00 must accompany this application.

Make check/money order payable to "General Treasurer, State of Rhode Island. Do not send cash.

Mail this application with fee to: Rhode Island Department of Health, 3 Capitol Hill, Room 205, Providence, RI 02908-5097.

If you have any questions, concerning this application contact the Medical Staff Office at the hospital in which you are applying for this license.

Licensure application materials are public records as mandated by Rhode Island law and may be made available to the public, unless otherwise prohibited by State or Federal Law.

CONTROLLED SUBSTANCE REGISTRAION

If you are also applying for a Rhode Island Controlled Substance Registration you must add an additional $100.00 to the license fee. For your information, in order to prescribe, administer and dispense Controlled Substances in this State, you are required to hold three items:

1) An active RI practice license
2) An active RI CSR
3) An active Federal Drug Enforcement Administration (DEA) Permit. While holding a training license you must use the Hospital's DEA number.

Are you applying for or renewing a RI Controlled Substance Registration (CSR) □ Yes □ No

If "yes", provide Hospital Federal DEA # _____

Rhode Island Department of Health
Military Expedition Form

Please attach this form to the *front* of your completed application and mail to the address shown on the application cover.

Pursuant to Rhode Island General Laws § 5-88-1 et seq., upon application, this state may recognize occupational licenses, certificates or permits obtained from other states for military members and their spouses who relocate to this state pursuant to military orders. The Rhode Island Department of Health (RIDOH) will expedite your or your spouse's health professional license application provided the following conditions are met.

I. PROFESSION/LICENSE TYPE

Please indicate the profession and/or license type you are applying for so that your application can be routed to the correct office:

Profession/License Type: _____

II. MILITARY STATUS

Please check ONE of the following criteria for expedition:

- ☐ I am in active military duty or a reservist.
- ☐ I am the spouse of someone in active military duty or the spouse of a reservist.
- ☐ I am a military veteran with honorable discharge. *You do not need to complete the rest of this application – please skip to the signature line.*

III. PROOF OF MILITARY STATUS

- ☐ Please attach a copy of proof of your military status such as one of the following: Leave Earning Statement (LES), Letter from Command, or Copy of Orders

IV. MILITARY CHANGE OF STATION ORDER

- ☐ Permanent Change of Station Order

V. PROOF OF GOOD STANDING

- ☐ Proof of good standing from the board in the other state in which the person has a license.

VI. Criminal Background Check (a "BCI") *(unless required in the initial license application)*

- ☐ BCI completed from the RI Attorney General's Office.

VII. ATTESTATIONS:

Check all that apply:

- ☐ No board in any other state has revoked the license for which I am applying as a result of negligence or intentional misconduct.
- ☐ I have never surrendered an occupational license, certificate, or permit because of negligence or intentional misconduct.
- ☐ I do not have a complaint, allegation, or investigation currently pending before a board in another state which relates to unprofessional conduct or an alleged crime.

I attest that the above responses and information are true and accurate to the best of my knowledge and that none of the information set forth above is false, erroneous, or defective in any important, as set forth in R.I. Gen. Laws § 11-18-1. I understand that this application is being made to the Rhode Island Department of Health, which shall rely upon my attestation and the information provided in this document.

Signature of Applicant Date

On a case-by-case basis RIDOH may grant a temporary license should the military member or spouse need additional time to complete education, training, and/or experience for the licensure in Rhode Island. RIDOH will contact the applicant directly should that be needed.