

APPLICATION FOR DENTAL FACULTY LICENSURE IN OREGON

SUMMARY: Prior to issuance of a Faculty Dental license, the Board must receive a completed application, \$305 application fee, \$210 biennial licensure fee, \$50 Prescription Drug Monitoring Fee, an official transcript, certificate of employment, fingerprint card and, if applicable, verification of licensure in another state or Canadian Province, or verification of having held an instructor's or faculty license, or verification of having successfully passing any clinical examination recognized by the Board, or verification of being certified by the appropriate national certifying examination body in a dental specialty.

APPLICATION INSTRUCTIONS

Submit the following to the Board in care of the Oregon Board of Dentistry, Unit 23, PO Box 4395, Portland, Oregon 97208-4395

1. A completed application (a blank form is enclosed). Your application will be forwarded to us after receipt of the fee is verified.
2. A non-refundable application fee of \$305, in the form of a cashier's check or money order, payable to the Oregon Board of Dentistry.
3. A biennial license fee of \$210.
4. A Prescription Drug Monitoring Program fee of \$50.

Submit the following to the Oregon Board of Dentistry, 1500 SW 1st, Suite 770, Portland, Oregon 97201.

1. Certification of Employment. Verification of being a full-time instructor of dentistry at OHSU, School of Dentistry engaged in dental activities (this verification must come directly from the Dean); and
2.
 - a. An official transcript showing satisfactory evidence of graduation from a school of dentistry accredited by the Commission on Dental Accreditation of the American Dental Association (CODA/ADA) must be submitted by your program to the Board; or
 - b. If you graduated from a dental school outside the United States or Canada, an official transcript showing successful completion of at least two years in an accredited, advanced dental education program. Transcript must be submitted by your program directly to the Board; and submit
 - A. Verification of current licensure to practice dentistry from another state or Canadian Province; or
 - B. Verification of having held an instructor's or faculty license to practice dentistry in another state or Canadian province immediately prior to becoming an instructor of dentistry at the Oregon Health & Sciences University; or
 - C. Verification of having successfully passed any clinical examination

recognized by the board for initial licensure; or

- D. Verification of being certified by the appropriate national certifying examination body in a dental specialty recognized by the American Dental Association.
3. If you answer “yes” to any of the questions on page two of the application, for any reason, you must submit additional supporting documentation for that question as indicated on the application.

This documentation should include:

- a. **Written letter of explanation** from you giving full details.
 - b. **Certified copies** of disciplinary action, police reports, court documents, and medical evaluations or any other pertinent information.
4. **Fingerprint Card – Out-of-State Applicants**
Fingerprints of applicants must be taken by a person qualified to take fingerprints.
(Check with your local law enforcement agency) The fingerprint card and the letter “To The Official Taking Fingerprints” must be returned by the Official in the enclosed envelope. [REQUEST FINGERPRINT CARD](#)

Fingerprints – Live Scan – Oregon
Live Scan fingerprints can only be transmitted electronically if fingerprints are taken in Oregon. Once the Oregon Board of Dentistry receives your application and application fee, we will send you the Request for Transmission for Live Scan Fingerprints form.
 5. **Jurisprudence Examination**
Once the application and application fee are received, the Jurisprudence Examination will be mailed to you. This examination is “open book” and may be returned to the Board by mail.
 6. **Faculty Practice Plan**
Copy of your Faculty Practice Plan from Oregon Health and Science University.

Application Valid For 180 Days (OAR 818-021-0120):

1. If all information and documentation necessary for the Board to act on an application is not provided to the Board by the applicant within 180 days from the date the application is received by the Board, the Board shall reject the application as incomplete.
2. An applicant whose application has been rejected as incomplete must file a new application and must pay a new application fee.

Fees Non-refundable – (ORS 679.120(8)):

All fees paid to the Board are non-refundable or transferable.

Please anticipate a minimum of 6 – 8 weeks for complete application processing. Once requested, documentation from other states or jurisdictions and background checks can take several weeks for processing.

WHERE FORMS ARE TO BE SENT:

The Application and the Biennial Licensure Forms and their fees are to be sent to Oregon Board of Dentistry, Unit 23, PO Box 4395, Portland, Oregon 97208-4395.

All supplemental forms, Official Transcripts, and Certificates of Standings from other states are to be sent directly to the Oregon Board of Dentistry, 1500 SW 1st Avenue, Suite 770, Portland, OR 97201.

Please note: the Board will match up all the above documents with the application which you send to Oregon Board of Dentistry, Unit 23, PO Box 4395, Portland, Oregon 97208-4395 with your fee.

ISSUANCE OF A DENTAL FACULTY LICENSE

Once all application materials and fees have been received, it will take approximately ten business days to issue a dental faculty license. A dental faculty license issued under this provision is restricted to the practice of dentistry in a facility devoted to dental care on the campus of Oregon Health and Science University.

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OREGON BOARD OF DENTISTRY

APPLICATION FOR LICENSURE

Date Application Received:	License No:
	Date License Issued:

1. Please complete on typewriter or in dark ink. Print legibly.
2. If additional space is needed, attach a separate sheet.
3. Make checks payable to the Oregon Board of Dentistry.
4. **Mail completed application to the Oregon Board of Dentistry, Unit 23, PO Box 4395, Portland, OR 97208-4395.**

I HEREBY APPLY FOR A LICENSE TO PRACTICE:

Dental Faculty Practice <input type="checkbox"/> Application fee (2111) \$305 <input type="checkbox"/> Licensure fee (2101) \$210 <input type="checkbox"/> Prescription Monitoring Program (1706) \$50	Dental Hygiene Faculty Practice <input type="checkbox"/> Application fee (2113) \$140 <input type="checkbox"/> Licensure fee (2103) \$100
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First Name	Middle Name	Last Name	
Other Names Used		Telephone Number	
Mailing Address/City, State, ZIP Code		Social Security Number	
Place of Birth		Date of Birth	
College Education (Name and Location)	From	To	Degree
Dental/Dental Hygiene School (s) (Name and Location)	From	To	Degree
Specialty Training or Specialty Board Membership	From	To	Degree

If the answer to any of the following questions is yes, provide details on a separate sheet (except 10a).
 (see "IMPORTANT INFORMATION" on Instruction Sheet)

1. Are you aware of any physical or mental condition that would inhibit your ability to practice safely?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. Have you ever been denied a license to practice dentistry or dental hygiene or denied the right to take an exam for such licensure?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. Have you ever voluntarily surrendered a license to practice dentistry or dental hygiene?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4. Has there been any disciplinary action, pending or final, regarding any dental or dental hygiene license you now hold or have ever held? (Include any disciplinary actions by the U.S. Military, U.S. Public Health Service, Drug Enforcement Administration, state licensing board or other entity.)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5. Has there been any investigation or disciplinary action taken against you by any dental or dental hygiene school or program?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
6. a. Have you ever been convicted of any offense, misdemeanor or felony which could have resulted in your imprisonment in a state, local or federal institution? (Even if not imprisoned.)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
b. Are there any pending criminal actions against you that could result in your imprisonment in a state, local or federal institution?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
7. Have you ever been convicted of any violation of any federal, state or local law relating to the possession, distribution, use or dispensing of mind altering or controlled substances?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
8. Have you ever used or possessed any drugs, or mind altering substances in violation of any law?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
9. Have you ever received treatment or counseling for abuse of alcohol, drugs or mind altering substances?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
10. a. Do you currently hold, or have you ever held, a license in this or any other state to practice a health care profession other than dentistry or dental hygiene? If yes, list on page 3.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
b. Has there been any disciplinary action, pending or final, regarding any health care professional license (other than dental or dental hygiene) by a licensing board?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Paste photograph here.
 Must be a passport type of photo taken within one year of application.
 On the photograph, sign and date across bottom in ink.

List all states in which you are or have been licensed or in which application is pending. Enter "None" or "Not Applicable" if none.	Type of License(s)			License No.	Date Issued	Status
	State	Dental	Dental Hygiene			

List in reverse chronological order all positions you have held in which you practiced dentistry or dental hygiene as well as any residencies or other formal training not otherwise listed on this application. Enter "None" or "Not Applicable" if none.

Description	Name of Institution or Employer	Location	From	To

AFFIDAVIT OF APPLICANT

STATE _____ OF _____
COUNTY _____ OF _____ SS.

I, hereby declare that I am the person described in the attached application for licensure.

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

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 or foreign) to release to the Oregon Board of Dentistry any information, files or records requested by the Board in connection with the processing of this application. I further authorize the Board to release to the organizations, individuals and groups listed above any information, which is material to my application.

Legal Signature

Type name as it appears on the application

Subscribed and sworn to before me this ____ day of _____, 20 ____.

Notary Public Signature

Notary Public for _____

My Commission Expires: _____

OREGON BOARD OF DENTISTRY
UNIT 23
PO BOX 4395
PORTLAND, OR 97208-4395

DENTAL BIENNIAL LICENSURE FEE

Enclose the biennial licensure fee of \$210.00, payable by cashier's check or money order to the Oregon Board of Dentistry, with this form and mail to the above address.

a. Name as you wish it to appear on your formal license

b. Mailing address

_____ Street or P.O. Box

City

State

Zip Code

Business address

_____ Street

City

State

Zip Code

Home address

_____ Street

City

State

Zip Code

c. Phone: Home

_____ Area Code - Telephone Number

Business

_____ Area Code - Telephone Number

Cell

_____ Area Code - Telephone Number

d. Email address

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CERTIFICATE OF LICENSURE
(Not applicable if no state licenses have been obtained)

Name of Applicant (Please Print or Type)		
Street Address		
City	State	Zip Code:
License No:	Date Issued:	

I certify that _____ was granted license number _____ to practice _____ in the State of _____, on the basis of successfully passing _____ examination.

STATUS OF LICENSE Current Expiration Date _____
 Expired Date _____
 Inactive Expiration Date _____
 Revoked Date _____

Type of License Issued Full
 Limited
 Conditional/Restricted (Please explain)

Legal/Disciplinary Action: Yes No
 Legal/Disciplinary Action Pending Yes No Unable to disclose

If yes, please attach copies of any disciplinary/legal action or pending disciplinary/legal action.

SEAL

Signature of Official

Title

Date Certificate Prepared

Return directly to:

**Oregon Board of Dentistry
1500 SW 1st Avenue, Suite 770
Portland, Oregon 97201**

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To The Applicant – Fill out this form if licensed in another State

Please complete the identifying information and submit to:

Drug Enforcement Administration
Attention: Pandora – Diversion Unit
300 5th Avenue, Suite 1300
Seattle, WA 98104
Telephone: 888-219-4261
Fax: 206-553-7757

Date: _____

To Whom It May Concern:

I am applying for a license to practice dentistry in the State of Oregon. Please indicate on the lower portion of this form if I have ever surrendered (for cause) or had a federal controlled substance registration revoked, suspended, restricted or denied.

Please send this form directly to the Oregon Board of Dentistry. Thank you for your assistance.

Name: _____

Date of Birth: _____

DEA Registration Number: _____

Address where DEA No. is Registered: _____

Signature of Applicant

Please Print Name

DEA Response:

Applicant has surrendered (for cause) or had a federal controlled substance registration revoked, suspended, restricted or denied: YES NO (Not to be completed by applicant!)

Please mail or fax to the following: Oregon Board of Dentistry
1500 SW 1th Avenue, Suite 770
Portland, OR 97201
Fax: (971) 673-3202

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Oregon

John A. Kitzhaber, MD, Governor

Board of Dentistry
1500 SW 1st Avenue
Suite 770
Portland, OR 97201-5828
(971) 673-3200
Fax: (971) 673-3202
www.oregon.gov/dentistry

PRIVACY ACT NOTIFICATION

As part of your application for an initial professional license, you are required to provide your Social Security Number to the Oregon Board of Dentistry (OBD). This is a mandatory requirement under Oregon Laws 1997, Chapter 746, section 117 (ORS 25.785) and under Federal Law USC section 666(a)(13)(a).

Failure to provide your Social Security Number will be a basis to refuse to issue your license.

The OBD will maintain a record of your Social Security Number in your licensing file.

The OBD is required to report your Social Security Number to the following entities:

- Division of Child Support – ORS 25.750 – 25.785
- Oregon Department of Revenue – ORS 305.380 – 305.385
- United States Health Care Integrity Protection Data Bank (HIPDB) – 45 CFR, Part 61, established under Section 1128E of the Social Security Act.
- National Practitioners Data Bank (NPDB) – Section (5) Medicare and Medicaid Patient and Program Protection Act of 1987.

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INFORMATION REQUESTED

The 2001 Legislature passed Senate Bill 786 (ORS 676.400), which requires that health professional regulatory boards maintain information regarding racial, ethnic and bilingual status of licensees and applicants and report to the data to the Legislature.

This law was the result of a study performed by the Governor’s Racial and Ethnic Health Task Force, which determined that access to health care by racial and ethnic minorities is inadequate to address the chronic health issues these communities face. People of color and people with native languages other than English experience extreme difficulty accessing health services. Culturally competent health care providers are critical in providing appropriate health care and the collection of the information requested below will assist decision makers in developing programs to address the disparity in access to health care experienced by various communities.

See the reverse of this page for racial and ethnic definitions from the State of Oregon employment documents and the US Census Bureau.

Provision of this information is voluntary. If you choose not to provide the information, it will have no effect on the acceptance or processing of your application or renewal.



Please print information

Name: _____

License No. _____

RACE: *Please check one.*

- White/Caucasian (not of Hispanic origin)
- Black/African American (not of Hispanic origin)
- Asian
- Hispanic/Latino
- Native American Indian/Alaska Native
- Native Hawaiian/Other Pacific Islander
- Other: _____

Ethnicity: _____ (e.g., American Indian tribe, Bengalese, Cambodian, Filipino, Guamanian, Haitian, Italian, Kenyan, Lebanese, Mexican, Norwegian, Polish, Russian, Samoan, Thai, etc.)

Languages: Please list languages, besides English, in which you are fully proficient or at least conversationally proficient, including American Sign Language.

Thank you for your assistance. Please return this survey with your application or renewal form, or you may mail or fax it at a later date.

OREGON BOARD OF DENTISTRY
1500 SW 1st Avenue, Suite 770
Portland, OR 97201
FAX: 971-673-3202