FOR OFFICE USE ONLY
Dental Volunteer Checklist

- ☐ Application
- ☐ Copy of Ourt of State License
- ☐ Sponsoring Agency Letter
- ☐ License Verification
- ☐ Continuing Education

FOR OFFICE USE ONLY

ID #

Issue Date

License #

Rhode Island
Board of Examiners in Dentistry

Room 104
3 Capitol Hill
Providence, RI 02908-5097

Instructions and License Application for:

Volunteer License

☐ Dentist
☐ Dental Hygienist

License # ____________

Name ____________

MILITARY STATUS ELIGIBILITY *(Documentation Required) see next page for instructions*

Please check ONE of the following criteria for expedited application:

☐ I am in active military duty or a reservist
☐ I am a military veteran with honorable discharge
☐ I am the spouse of someone in active military duty or the spouse of a reservist

Applicant - Print Name

LAST NAME	***FIRST NAME***	***MI***

Phone: (401) 222-2837 **TTY/TDD: (800) 745-5555** **Fax: (401) 222-2158**

IMPORTANT LICENSE INFORMATION

The Rhode Island Board of Examiners in Dentistry may issue a special license to qualifying dentists and dental hygienists under the terms and conditions set forth in this section. The special license may only be issued to a person who is licensed in the practice of dentistry or dental hygiene in another state and who has maintained full licensure in good standing in dentistry or dental hygiene in any state.

The special licensee shall be permitted to practice dentisry or dental hygiene only in the non-compensated employ of public agencies or institutions, not-for-profit agencies, not-for-profit institutions, nonprofit corporations, or not-for-profit associations which provide dentistry or dental hygiene services only to indigent patients in areas which are underserved by dentists or dental hygienists or critical need population areas of the state.

This special license issued by this application is valid only for the event you are applying for at this time and will be made invalid and unusable upon termination of the event. If you choose to participate in any other even at any other time, you will need to reapply for a new license.

Any application fee shall be waived for the holder of this special license.

LICENSURE REQUIREMENTS

- ☐ Completed, Notarized Application with Cover Page - Applications are valid for 1 year from the day they are received at RIDOH. If you are not licensed within the year you must submit a new application.
- ☐ Current copy of out-of-state dental/dental hygiene license.
- ☐ Notarized statement from the sponsoring agency whereby it is agreed beween the parties that no compensation shall be paid for any dentistry or dental hygiene services rendered while in possession of this volunteer license. (Statement of Sponsoring Agency Form included in this application to be used for that purpose). This form can be duplicated and must be completed for each employing agency, institutuion, corporation, association or health care program.
- ☐ If you have ever been licensed in another state, license verification(s) must be sent directly from the state(s) in which you hold or have held a license. (Interstate Verification Form included in this application can be used for that purpose)
- ☐ Compliance with continuing education requirements established by the board of dental examiners in the state in which you are licensed.
- ☐ If applying for expedited military status, please complete the Military Expedition Form at the end of this application packet.

Licensure Information

Please visit the RIDOH website at **http://www.health.ri.gov/licenses** to Verify your license, download Rules and Regualtions/Laws for your profession, download change of address forms, other licensing forms or obtain our contact information. HEALTH will not, for any reason, accelerate the processing of one applicant at the ex pense of others.

State of Rhode Island
Board of Examiners in Dentistry

Refer to the Application Instructions when completing these forms. Type or block print only. Do not use felt-tip pens.

1. Name(s)

This is the name that will be printed on your License/Permit/Certificate and reported to those who inquire about your License/Permit/Certificate. Do not use nicknames, etc.

All questions MUST be answered. Enter "NA" for any question that is NOT APPLICABLE.

First Name

Middle Name

Surname, (Last Name)

Suffix (i.e., Jr., Sr., II, III)

Degree (DMD,DDS)

Maiden, if applicable

Name(s) under which originally licensed in another state, if different from above (First, Middle, Last).

____

2. Social Security Number

U.S. Social Security Number

"Pursuant to Title 5, Chapter 76, of the Rhode Island General Laws, as amended, I attest that I have filed all applicable tax returns and paid all taxes owed to the State of Rhode Island, and I understand that my Social Security Number (SSN) will be transmitted to the Divison of Taxation to verify that no taxes are owed to the State."

3. Home Address

It is your responsibility to notify the board of all address changes.

1st Line Address (Apartment/Suite/Room Number, etc.)

Second Line Address (Number and Street)

City

State

Zip Code

Country, If NOT U.S.

Postal Code, If NOT U.S.

Home Phone

Home Fax

Email Address (Format for email address is Username@domain e.g. applicant@isp.com)

4. Sponsoring Agency Name and Address

If sponsored by more then one agency, please attach a separate sheet with the required information.

Name of Business/Work Location

1st Line Address (Department/Suite/Room Number, etc.)

Second Line Address (Number and Street)

City

State

Zip Code

Country, If NOT U.S.

Postal Code, If NOT U.S.

Business Phone

Extension

Business Fax

It is your responsibility to notify the board of all locations where you will be providing dental/dental hygiene services. A notarized statement from each sponsoring agency, institution, corporation, association or health care program on a form prescribed by the board, whereby he or she agrees unequivocally not to receive compensation for any dentistry or dental hygiene services he or she may render while in possession of this special license.

5. Current Licensure

I am currently licensed in the practice of dentistry or dental hygiene in the state of

[|] under license number [| | | | | | | | | |]

and have maintained full licensure in good standing. Furthermore, I am in compliance with the continuing education requirements established by the board of dental examiners in the state in which I am licensed.

6. Affidavit of Applicant

Complete this section and sign.

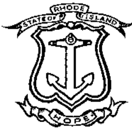
Make sure that you have completed all components asdfaccurately and completely.

I, ____________________________________, affirm that the information provided on this application form and the documentation provided to support this application is true, accurate complete, and unaltered. I acknowledge that, pursuant to RIGL 11-18-1, knowingly making a false statement on this application form is punishable as a misdemeanor, and that such an act shall constitute cause for denial, suspension, or revocation of my license/permit to practice Dental Hygiene in the State of Rhode Island.

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

____
Signature of Applicant

____
Date of Signature (MM/DD/YY)



Rhode Island Board of Examiners in Dentistry
Room 104, 3 Capitol Hill
Providence, RI 02908-5097
(401) 222-2828

STATEMENT OF SPONSORING AGENCY

I,______________________________________ , Director ____________________________________
(Agency Representative) (Sponsoring Agency)

____
Agency Address Street City ZipCode

Have entered into a contract with____ who agrees
(Dentist/Dental Hygienist Name)

unequivocally not to receive compensation for any dentistry or dental hygiene services he or she may render under this volunteer license. This volunteer license permits the practice of dentistry or dental hygiene only in the non-compensated employ of public agencies or institutions, not-for-profit agencies, not-for-profit institutions, nonprofit corporations, or not-for-profit associations which provide dentistry or dental hygiene services only to indigent patients in areas which are underserved by dentists or dental hygienists.

______________________________________ ______________________________________
Dentist/Dental Hygienist Signature Director's Signature

______________________________________ ______________________________________
Date Date

Substitute forms are not acceptable. This form may be duplicated as needed.

Rhode Island Board of Examiners in Dentistry

Room 104, 3 Capitol Hill
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(401) 222-2828

INTERSTATE VERIFICATION FORM

I am applying for a license to practice dental hygiene in the State of Rhode Island. The Rhode Island Board of Examiners in Dentistry requires that the following form be completed by the jurisdiction in which I am now or was previously licensed. This constitutes your authority to release all information in your files, favorable or otherwise, directly to the Rhode Island Board of Examiners in Dentistry at the above address.

Print/Type Full Name ____________________ Signature ____________________ Date __________

Previous Names Used ____________________ Social Security Number ____________________ Date of Birth __________

License Number ____________________ Date Issued __________

THIS SECTION TO BE COMPLETED BY THE DENTAL BOARD

Basis for issuing License:

☐ ADA National Board ☐ NERB ☐ Other Regional Board ☐ State Exam ________ (State)

If a combination of exams were taken, please list the specific combination:

License Status: ☐ Active ☐ Inactive ☐ Lapsed	**Original Date Issued:**	**Expiration Date:**

Questions:

1. Has this dental hygienist ever been investigated by your Board? ☐ Yes ☐ No
2. Has this dental hygienist incurred any disciplinary proceedings in your state, or is any action pending? ☐ Yes ☐ No
3. Has the applicant's license ever been denied, surrendered, reprimanded, suspended, revoked or placed on probation? ☐ Yes ☐ No
4. Do you know of any information that may discredit this person? ☐ Yes ☐ No

If you answer "Yes" to questions 1-4, please provide a written explanation below, and attach a copy of all supporting documentation (e.g., Board order, complaint, etc.).

____

____

____

Certification:

Signature ____________________ Date __________

Type or Print Name ____________________

Title ____________________

Full Name and of Licensing Board including State ____________________

Please return directly to the Board at the above address. Thank you for your prompt cooperation.

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.