FOR OFFICE USE ONLY DAANCE Checklist
☐ App & Fee ($40.00)
☐ Valid Photo ID
☐ DAANCE Certification
☐ Advanced Cardiac Life Support Certification (ACLS)
☐ Verification from other state(s), if applicable

FOR OFFICE USE ONLY
Receipt #
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:

DAANCE Certified Maxillofacial Surgery Assistant

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) 222-2828 **TTY/TDD: (800) 745-5555** **Fax: (401) 222-1272**

Revised 11/07/2018 jcp

LICENSURE REQUIREMENTS

- [ ] Completed 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.

- [ ] Check or money order (preferred), made payable (in U.S. funds only) to the RI General Treasurer in the amount of **$40.00** and attached to the upper left-hand corner of the first (Top) page of the application. THIS APPLICATION FEE IS NONREFUNDABLE. Please be advised that this is an application fee and includes the first license **only** up until the next expiration date.

- [ ] Copy of driver's license or state issued ID

- [ ] Score/Certification sent directly from the Dental Anesthesia Assistants National Certification Examination.

- [ ] Copy of Certificate of completion of an approved course in Advanced Cardiac Life Support (ACLS)

- [ ] 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)

- [ ] 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.

License Certificates

RIDOH will be providing wallet license cards ONLY on issuance of licenses. If you wish to receive a license certificate, suitable for framing, please check the box below and attach a separate check in the amount of $30.00 made payable to RI General Treasurer.

- [ ] I would like to receive a license certificate. I have enclosed a separate check in the amount of $30.00

State of Rhode Island
Board of Examiners in Dentistry
Application for A DAANCE License

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.

Title (i.e., Mr., Mrs., Ms., etc.)

First Name

Middle Name

Surname, (Last Name)

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

Degree

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. Gender

☐ Male ☐ Female

4. Date of Birth

Month Day Year

5. Home Address

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

Home Addresses are not published information.

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)

6. Primary Business Address

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

This address will appear on the Department of Health web site.

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

7. Preferred Mailing Address

Please check ONE

☐ Please use my **Home Address** as my preferred mailing address

☐ Please use my **Business Address** as my preferred mailing address

8. DAANCE Certification Examination

Date Completed _____ Month _____ Year

Passed? ☐ Yes ☐ No

9. DAANCE Licensure

List all states or countries in which you are now, or ever have been licensed to practice as a DAANCE Certified Maxillofacial Surgery Assistant or any other profession.

State/Country:			State/Country:		
	☐ Active	☐ Inactive		☐ Active	☐ Inactive
	☐ Active	☐ Inactive		☐ Active	☐ Inactive
	☐ Active	☐ Inactive		☐ Active	☐ Inactive

10. Board Discipline

List any disciplinary actions by licensing boards in other states. Please describe any prior or pending Board action or investigation. Please attach any relevant supplemental materials. If necessary, you may continue on a separate 8 1/2 X 11 sheet of paper.

☐ Check here if not applicable.

Licensing Board (abbreviate) and Nature of Action (e.g. TX - Professional Misconduct):	Month	Year	Type of Discipline:

Please describe any prior or pending Board action or investigation. Please attach any relevant supplemental materials.

11. Criminal Convictions

Respond to the question at the top of the section, then list any criminal conviction(s) in the space provided.

If necessary, you may continue on a separate 8 1/2 X 11 sheet of paper.

Have you ever been convicted of a violation, pled Nolo Contendere, or entered a plea bargain to any federal, state or local statute, regulation, or ordinance or are any formal charges pending; including use of illicit substances or operating a motor vehicle while intoxicated. (Please include any offenses which have been expunged from your record)? ☐ Yes ☐ No

Abbreviation of State and Conviction[1] (e.g. CA - Illegal Possession of a Controlled Substance):

	Month	Year

☞

[1]For purposes of this section, a person shall be deemed to be convicted of a crime if he/she plead guilty or if he/she was found or adjudged guilty by a court of competent jurisdiction or has been convicted of a felony by the entry of Nolo Contendere in any state.

12. Disciplinary Questions

Check either Yes or No for each question.

1. Has any Health Professional license, certificate, registration, or permit you hold or have held, been disciplined or are any formal charges pending? ☐ Yes ☐ No

2. Have you ever been denied a license, certificate, registration or permit in any state? ☐ Yes ☐ No

☞ **Note:** If you answer "Yes" to any question, you are **required** to furnish complete details, including date, place, reason and disposition of the matter.

13. Affidavit of Applicant

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 as a DAANCE Certified Maxillofacial Surgery Assistant 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)

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

Rhode Island Board of Examiners in Dentistry

Room 104, 3 Capitol Hill
Providence, RI 02908-5097
(401) 222-2828

RECIPROCITY RELEASE FORM

I am applying for a license to practice as a DAANCE Certified Maxillofacial Surgery Assistant 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:

☐ AAOMS National Certification Exam ☐ Other Exam

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 applicant ever been investigated by your Board? ☐ Yes ☐ No
2. Has this applicant 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 Affix
Board Seal Here

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.