Rhode Island
Board of Examiners in Dentistry
Room 205
3 Capitol Hill
Providence, RI 02908-5097

Instructions and License Application for:

Volunteer License

☐ Dentist
☐ Dental Hygienist

MILITARY STATUS ELIGIBILITY

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
Pursuant to Chapter 5-31.1-6 (e) of the General Laws of the State of Rhode Island:

(1) 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.

(2) The special licensee shall be permitted to practice dentistry or dental hygiene only in the non-compensated employment 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.

(3) The person applying for the special license under this section shall submit to the board a notarized statement from the 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.

(4) Any application fees and all licensure and renewal fees shall be waived for the holder of this special license.

(5) A dentist or dental hygienist licensed pursuant to this section shall comply with the continuing education requirements established by the board of dental examiners in the state in which they are licensed.

**Military Expedited**

If applying for expedited military status you must include one of the following: Leave Earning Statement (LES), Letter from Command, Copy of Orders or DD-214 showing honorable discharge.

**Application Process**

Complete and submit application along with the following:

1. Current copy of dental/dental hygiene license or letter of good standing from the state where practitioner is currently licensed to practice.

2. Notarized statement from the sponsoring agency* whereby it is agreed between the parties that no compensation shall be paid for any dentistry or dental hygiene services rendered while in possession of this volunteer license.

*You must provide a notarized statement from each employing agency, institution, corporation, association or health care program on the provided “Sponsoring Agency Form” (you may duplicate this form as needed). This license is valid for the practice only at those agencies that have provided a notarized statement as described in above item 2.
APPLICATION PROCESS OVERVIEW

Complete all pages of the application. Do not submit applications without all applicable information and documentation. Mail these components of the application to:

Rhode Island Board of Examiners in Dentistry  
Room 205  
3 Capitol Hill  
Providence, RI 02908-5097

HEALTH will not, for any reason, accelerate the processing of one applicant at the expense of others. Once completed, the application will be reviewed, and you will be contacted in writing.

Please continue to review the remaining portions of this application packet for instructions and other materials necessary to complete the Board application. If you have any questions about this application process, or would like to check on the status of your Board application, please contact this office at (401) 222-2837.

General Instructions

1. Make a copy of the application and forms before you begin, in case you make a mistake.

2. Type your information or print in blue or black ball-point pen. Board staff will not make assumptions about illegible information. Be sure to print your name in the box provided on the cover page.

3. Provide a response to each section or question; otherwise, mark “N/A” for Not Applicable.

4. We suggest that you make a copy of your completed application before submitting it to the Board.

5. It is your responsibility to check on the status of your application on the verifications page of the Department of Health website at: www.health.ri.gov

APPLICATION CHECKLIST

Please review the following checklist to ensure you have satisfied all components of the application process. I have arranged my Board Application materials in the following order.

1. Board Application
2. Notarized statement from the sponsoring agency whereby it is agreed between the parties that no compensation shall be paid for any dentistry or dental hygiene services rendered while in possession of this volunteer license.

PLEASE NOTE THE FOLLOWING IMPORTANT INFORMATION:

1. You must contact your sponsoring organization to complete their specific application process.

2. Please be aware that the license issued to you 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 event at any other time, you will need to reapply for a new license.
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.

<table>
<thead>
<tr>
<th>First Name</th>
<th>Middle Name</th>
<th>Surname, (Last Name)</th>
<th>Suffix (i.e., Jr., Sr., II, III)</th>
<th>Degree (DMD, DDS)</th>
</tr>
</thead>
</table>

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

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

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 Division 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.

<table>
<thead>
<tr>
<th>1st Line Address (Apartment/Suite/Room Number, etc.)</th>
<th>Second Line Address (Number and Street)</th>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Country, If NOT U.S.</th>
<th>Postal Code, If NOT U.S.</th>
<th>Home Phone</th>
<th>Home Fax</th>
</tr>
</thead>
</table>

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

4. Sponsoring Agency Name and Address

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

<table>
<thead>
<tr>
<th>Name of Business/Work Location</th>
<th>1st Line Address (Department/Suite/Room Number, etc.)</th>
<th>Second Line Address (Number and Street)</th>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Country, If NOT U.S.</th>
<th>Postal Code, If NOT U.S.</th>
<th>Business Phone</th>
<th>Extension</th>
<th>Business Fax</th>
</tr>
</thead>
</table>

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.

6. Affidavit of Applicant

The foregoing instrument was acknowledged before me this _______________ day of

___________________________, 20____, by ________________________________

(Applicants Name)

who is personally known to me or has produced ____________________________,

(i.e. license/ID, etc.)

as documentation and did/ did not take an oath.

___________________________

Applicant’s Signature

___________________________

Notary Public
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

The foregoing instrument was acknowledged before me this __________________ day of ___________________________ , 20______, who is personally known to me or has produced ___________________________ , as documentation and did/did not take (i.e. license/ID, etc.) an oath.

Notary Public

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