

- 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**

**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

\_\_\_\_\_  
Signature of Notary

My Commission Expires on: \_\_\_\_\_

\_\_\_\_\_  
Name of Notary Typed, Printed or Stamped

NOTARY SEAL

**CERTIFICATION OF APPOINTMENT**

To be completed by the Administrator or CEO of the hospital 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 Position and Year  
(Intern/Resident/Fellow)

\_\_\_\_\_  
Name of Hospital Beginning Date Ending Date

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

\_\_\_\_\_  
Day Month Year

\_\_\_\_\_  
Original Signature of Hospital Administrator Date of Signature

**Important: To be completed only for First temporary licensure in RI**

**CERTIFICATION BY DEAN OF DENTAL SCHOOL**

This certifies that the Applicant named below has creditably completed not less than 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)



## 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 \$50.00 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 I 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 \$70.00 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 # \_\_\_\_\_