

FOR OFFICE USE ONLY
Dental Volunteer Checklist

- Application
- Copy of Out 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

License # _____

Name _____

- Dentist
- Dental Hygienist

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 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 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 between 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, institution, 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 you must include one of the following: Leave Earning Statement (LES), Letter from Command, Copy of Orders or DD-214 showing honorable discharge.

Licensure Information

Please visit the RIDOH website at <http://www.health.ri.gov/licenses> to Verify your license, download Rules and Regulations/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 expense 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 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.

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 than 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

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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
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(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.

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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.).

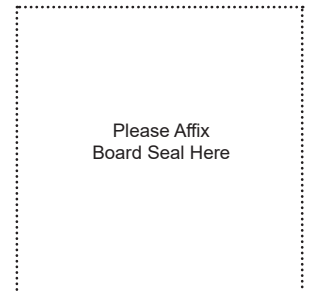
Certification:

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.