Residency/Intern Application

Board of Dentistry
P.O. Box 6330
Tallahassee, FL 32314-6330
Website: www.floridasdentistry.gov
Email: info@floridasdentistry.gov
Phone: (850) 245-4474
FAX: (850) 921-5389

Florida HEALTH
Medical Quality Assurance

Residency/Intern Application

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P.O. Box 6330
Tallahassee, FL 32314-6330
Fax: (850) 921-5389
Email: info@floridasdentistry.gov

This application is pursuant to chapter (ch.) 466.025(1), Florida Statutes (F.S.) and Rules 64B5-7.001 and 64B5-7.003, Florida Administrative Code (F.A.C.). Any questions that are not applicable must be indicated as N/A.

Are you applying for an initial permit? ☐ Yes ☐ No

If "No," when did you enter the residency program? _____ **Permit #:** _____
MM/DD/YYYY

1. PERSONAL INFORMATION

Name: _____ **Date of Birth:** _____
Last/Surname First Middle MM/DD/YYYY

Local Mailing Address: (The address where mail and your license should be sent)

_____ _____ _____
Street/P.O. Box Apt. No. City

_____ _____ _____ _____
State ZIP Country Home/Cell Telephone (Input without dashes)

Name of Institution Seeking Approval:_____

Mailing Address of Institution: _____ _____
Street/P.O. Box City

_____ _____ _____
State ZIP Name of Resident Director of Chief

Name(s) and License Number(s) of Florida licensed dentist(s) providing supervision:

Last Name	First Name	License #

Email Notification: To be notified of the status of your application by email, check the "Yes" box and fill in your email address on the line provided. If you choose to be notified via email you will be responsible for checking your email regularly and updating your email address with the board office.

☐ Yes ☐ No Email Address: _____

Under Florida law, email addresses are public records. If you do not want your email address released in response to a public records request, do not provide an email address or send electronic mail to our office. Instead contact the office by phone or in writing.

2. SOCIAL SECURITY DISCLOSURE

This information is exempt from public records disclosure.

Last Name: _____

First Name: _____

Middle Name: _____

Social Security Number: _____
(Input without dashes)

Pursuant to Title 42 United States Code § 666(a)(13), the department is required and authorized to collect Social Security numbers relating to applications for professional licensure. Additionally, section (s.) 456.013(1)(a), F.S., authorizes the collection of Social Security numbers as part of the general licensing provisions.

3. APPLICANT BACKGROUND

A. Have you ever changed your name through marriage or through action of a court, or have you ever been known by any other name? ☐ Yes ☐ No

If "Yes," list name(s) and date(s) of change(s):

_____

B. Are you registered with the Drug Enforcement Administration (DEA) to prescribe controlled substances?
☐ Yes ☐ No

If "Yes," provide your DEA #: _____

4. EDUCATION HISTORY

A. List all dental/medical school(s) attended.

School Name/Address	Graduation Date (MM/DD/YYYY)	Degree Awarded

All applicants must provide a copy of a diploma or a final transcript.

B. Have you received training and hold current certification from the American Heart Association, the American Red Cross, or entity with equivalent requirements in cardiopulmonary resuscitation (CPR) at the basic support level, including one-rescuer and two-rescuer CPR for adults, children, and infants; the use of an automatic external defibrillator (AED); and the use of ambu-bags? ☐ Yes ☐ No

☐ American Heart Association	Certification #:
☐ American Red Cross	Issue Date (MM/DD/YYYY):
☐ Other: _____	Expiration Date (MM/DD/YYYY):

Name: _____

This information is exempt from public records disclosure.

5. HEALTH HISTORY

Physical and Mental Health Disorders Impacting Ability to Practice

A. During the last two years, have you been treated for or had a recurrence of a diagnosed physical or mental disorder that impaired or would impair your ability to practice? ☐ Yes ☐ No

B. In the last two years, have you been admitted or referred to a hospital, facility or impaired practitioner program for treatment of a diagnosed mental or physical disorder that impaired your ability to practice? ☐ Yes ☐ No

Substance-Related Disorders Impacting Ability to Practice

C. During the last five years, have you been treated for or had a recurrence of a diagnosed substance-related (alcohol or drug) disorder that impaired or would impair your ability to practice? ☐ Yes ☐ No

D. During the last five years, were you admitted or directed into a program for the treatment of a diagnosed substance-related (alcohol or drug) disorder or, if you were previously in such a program, did you suffer a relapse? ☐ Yes ☐ No

E. During the last five years, have you been enrolled in, required to enter, or participated in any substance-related (alcohol or drug) recovery program or impaired practitioner program for treatment of drug or alcohol abuse? ☐ Yes ☐ No

If a "Yes" response was provided to any of the questions in this section, provide the following documents directly to the board office:

☐ **A letter from a Licensed Health Care Practitioner,** who is qualified by skill and training to address the condition identified, which explains the impact the condition may have on the ability to practice the profession with reasonable skill and safety. The letter must specify that the applicant is safe to practice the profession without restrictions or specifically indicate the restrictions that are necessary. Documentation provided must be dated within one year of the application date.

☐ **A written self-explanation,** identifying the medical condition(s) or occurrence(s); and current status

Name: _____

6. DISCIPLINE HISTORY

A. Have you ever been denied the right to take a Dentistry or Dental Hygiene examination in any state?
☐ Yes ☐ No

B. Have you ever been refused a license to practice Dentistry, Dental Hygiene or any other license, or the renewal thereof in any state? ☐ Yes ☐ No

C. Are you now or have you ever been a defendant in civil litigation in which the basis of the complaint against you was alleged negligence, malpractice, or lack of professional competence? ☐ Yes ☐ No

D. In any jurisdiction, do you have a pending complaint against your professional conduct or competence as a Dentist or Dental Hygienist? ☐ Yes ☐ No

E. Have you ever had a license or certificate of registration to practice Dentistry, Dental Hygiene, or any other license profession revoked, suspended, or otherwise acted against (including probation, fine, or reprimand) in a disciplinary proceeding in any state? ☐ Yes ☐ No

If you responded "Yes" to any of the questions in this section, complete the following:

Name of Agency	State	Action Date (MM/DD/YYYY)	Final Action	Under Appeal?
				☐ Y ☐ N
				☐ Y ☐ N
				☐ Y ☐ N

If you responded "Yes" to any of the questions in this section, you must provide the following:

☐ **A written self-explanation**, describing in detail the circumstances surrounding the disciplinary action.

☐ A copy of the **Administrative Complaint** and **Final Order**.

Name: _____

7. CRIMINAL AND MEDICAID/MEDICARE FRAUD QUESTIONS

IMPORTANT NOTICE: Applicants for licensure, certification, or registration and candidates for examination may be excluded from licensure, certification, or registration if their felony convictions fall into certain timeframes as established in s. 456.0635(2), F.S.

1. Have you been convicted of, or entered a plea of guilty or nolo contendere, regardless of adjudication, to a felony under ch. 409, F.S. (relating to social and economic assistance), ch. 817, F.S. (relating to fraudulent practices), ch. 893, F.S. (relating to drug abuse prevention and control), or a similar felony offense(s) in another state or jurisdiction? ☐ Yes ☐ No

If you responded "No" to the question above, skip to question 2.

   a. If "Yes" to 1, for the felonies of the first or second degree, has it been more than 15 years from the date of the plea, sentence, and completion of any subsequent probation? ☐ Yes ☐ No

   b. If "Yes" to 1, for the felonies of the third degree, has it been more than ten years from the date of the plea, sentence, and completion of subsequent probation (this question does not apply to felonies of the third degree under s. 893.13(6)(a), F.S.)? ☐ Yes ☐ No

   c. If "Yes" to 1, for the felonies of the third degree under s. 893.13(6)(a), F.S., has it been more than five years from the date of the plea, sentence, and completion of any subsequent probation? ☐ Yes ☐ No

   d. If "Yes" to 1, have you successfully completed a drug court program that resulted in the plea for the felony offense being withdrawn or the charges dismissed (If "Yes," provide supporting documentation)? ☐ Yes ☐ No

2. Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, to a felony under 21 U.S.C. ss. 801-970 (relating to controlled substances) or 42 U.S.C. ss. 1395-1396 (relating to public health, welfare, Medicare and Medicaid issues)? ☐ Yes ☐ No

If you responded "No" to the question above, skip to question 3.

   a. If "Yes" to 2, has it been more than 15 years before the date of application since the sentence and any subsequent period of probation for such conviction or plea ended? ☐ Yes ☐ No

3. Have you ever been terminated for cause from the Florida Medicaid Program pursuant to s. 409.913, F.S.? ☐ Yes ☐ No

If you responded "No" to the question above, skip to question 4.

   a. If you have been terminated but reinstated, have you been in good standing with the Florida Medicaid Program for the most recent five years? ☐ Yes ☐ No

4. Have you ever been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid program? ☐ Yes ☐ No

If you responded "No" to the question above, skip to question 5.

   a. Have you been in good standing with a state Medicaid program for the most recent five years? ☐ Yes ☐ No

   b. Did termination occur at least 20 years before the date of this application? ☐ Yes ☐ No

Name: _____

5. Are you currently listed on the United States Department of Health and Human Services' Office of the Inspector General's List of Excluded Individuals and Entities (LEIE)? ☐ Yes ☐ No

   a. If you responded "Yes" to the question above, are you listed because you defaulted or are delinquent on a student loan? ☐ Yes ☐ No

   b. If you responded "Yes" to question 5.a., is the student loan default or delinquency the only reason you are listed on the LEIE? ☐ Yes ☐ No

If you responded "Yes" to any of the questions in this section, you must provide the following:

☐ **A written self-explanation** for each question including the county and state of each termination or conviction, date of each termination or conviction, and copies of supporting documentation to the address listed on the first page of the application.

☐ **Supporting documentation** including court dispositions or agency orders where applicable.

Documents in sections 5, 6, and 7 must be sent to the board office at info@floridasdentistry.gov, or mailed to:

Board *of* Dentistry
4052 Bald Cypress Way Bin C-04
Tallahassee, FL 32399-3258

8. APPLICANT RELEASE

I, _____, state that I am the person referred to in the foregoing Residency/Intern permit application and supporting documentation, that said application and any supporting documentation are true and accurate.

I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past and present), business and professional associates (past and present), and all governmental agencies and instrumentalities (local, state, federal and foreign) to release to the Florida Department of Health any information, files, or records requested by the agency in connection with the processing of this application. I further authorize the Florida Department of Health to release to any organization, individual or group listed above any information which is material to my application.

I understand that it is my responsibility to supplement my application as needed to reflect any material changes in any circumstance or condition stated in the application which might affect the decision of the department and which takes place between the initial filing of the application and the final granting or denial of residency/intern permit.

I have carefully read the instructions and questions in the foregoing application and have answered them completely, without reservations of any kind. Should I furnish any false information in this application, or in any supporting documentation, I acknowledge that such an act constitutes cause for denial, disciplinary action, suspension or revocation of my residency/intern permit to practice dentistry under ch. 466, F.S., ch. 456, F.S., and ch. 64B5, F.A.C., in the state of Florida.

I hereby acknowledge and state that I have received, read and understood ch. 466, F.S., ch. 456, F.S., and ch. 64B5, F.A.C, and acknowledge that I must abide by them.

Applicant Signature _____ Date _____
MM/DD/YYYY