

## **APPLICATION FOR LIMITED LICENSURE DENTIST/DENTAL HYGIENIST**

### **Statute and Rule References:**

- Section 456.015, Florida Statutes
- Rule 64B5- 7.007, Florida Administrative Code

### **General Requirements and Information**

The following criteria **MUST** be met in order to obtain dentist/dental hygienist limited licensure in Florida:

- The applicant has retired or intends to retire from the practice of dentistry/dental hygiene and intends to practice only pursuant to the restrictions of the limited license; **AND**
- The applicant was licensed to practice dentistry/dental hygiene in any jurisdiction in the United States for at least 10 years.

The limited licensee can practice only in the employ of public agencies or non-profit agencies or institutions which meet the requirements of s. 501(c)(3) of the Internal Revenue Code that are permitted under rule 64B5-7.006 and which provide professional liability coverage for acts or omissions of the limited licensee. Limited licensees may provide services only to the indigent or critical need populations within the state.

### **Continuing Education Requirement:**

Pursuant to Rule 64B5-7.007(1)(d), F.A.C., the board shall require each limited licensee to complete the same continuing education requirements that are applicable to regular active licensees.

Dentists: 30 continuing education hours to include a 2 hour course in the prevention of medical errors and a 2 hour course on prescribing controlled substances each biennium. A course in HIV/AIDS is required no later than the first renewal and a 2 hour course in domestic violence is required every third biennium. In addition to the 30 continuing education hours, re-certification in CPR at the basic life support level and as defined in Rule 64B5-12.020, F.A.C., is required.

Dental Hygienists: 24 continuing education hours to include 2 hour course in the prevention of medical errors each biennium. A course in HIV/AIDS is required no later than the first renewal and a 2 hour course in domestic violence is required every third biennium. In addition to the 24 continuing education hours, re-certification in CPR at the basic life support level and as defined in Rule 64B5-12.020, F.A.C., is required.

**Applications that do not include a fee and/or supporting documents should be mailed to Department of Health, Board of Dentistry, 4052 Bald Cypress Way, Bin #C08, Tallahassee FL 32399-3258.**

### **REQUIRED DOCUMENTATION INCLUDES:**

- Proof of current CPR certification
- Verifications of licensure **MUST** be sent directly to the board office from the respective agency.
- Proof of graduation from dental school

**PLEASE TYPE OR PRINT LEGIBLY ALL INFORMATION**

# Application for Limited License Dental/Dental Hygiene

PO Box 6330  
Tallahassee, FL 32314-6330  
Phone: (850) 245-4474  
Fax: (850) 921-5389

Do Not Write in this Space  
For Revenue Receiving Only

**Please complete this application in its  
entirety prior to submitting**

Fees must be paid in the form of a cashier's check or money order, made payable to: DOH Florida Board of Dentistry

**APPLICATION METHOD:** Please check the box applicable to your proposed practice setting.

- Non-Remunerated (Volunteer - not paid for services). Must submit Fee Waiver Affidavit  
 Remunerated (Paid employee) total due: \$305.00 – Dentist \$105.00 – Dental Hygienist

## 1. Application Profile Data

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Last First Middle MM/DD/YYYY

**Mailing Address: (Give the address where mail and your license should be sent)**

Street/PO Box Apt. No. City

State Zip Country Primary Telephone

**Physical Location: (Required if mailing address is a P.O. Box- This address will be posted on the Department of Health's website.)**

Street Apt./Suite No. City

State Zip Country Secondary Telephone

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): \_\_\_\_\_

**Email Notification:** If you want to be notified of the status of your application by email please check the "Yes" box and write your email address on the line provided below. If you choose this form of notification, you will receive information regarding your application file through 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 e-mail address released in response to a public records request, do not provide an email address or send electronic mail to our office.

**Equal Opportunity Data:** We are required to ask that you furnish the following information as part of your voluntary compliance with Section 2, Uniform Guidelines on Employee Selection Procedure (1978) 43 FR 38296 (August 25, 1978). This information is gathered for statistical and reporting purposes only and does not in any way affect your candidacy for licensure.

RACE:  White  Black or African American  Asian  American Indian or Alaska Native  Hispanic  Two or More Races

**2. Applicant Education – Please attach a copy of your diploma**

Dental School Attended: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Degree:  DDS  DMD  AS  Other \_\_\_\_\_ Date Graduated: \_\_\_\_\_

**3. Applicant Licensure Status**

Do you now hold or have you ever held a license to practice Dentistry or Dental Hygiene in any state, U.S. territory or foreign country? (List most recent first)  Yes  No

State/Jurisdiction	License No.	Issue Date	If no longer licensed, state why and when
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**4. Practice Affirmation and History**

Do you affirm that you have practiced dentistry/dental hygiene as a licensed dentist/dental hygienist for at least ten years in the United States?  Yes  No

Do you affirm that you have retired or intend to retire from the practice of dentistry/dental hygiene?  Yes  No  
Please give the date (mm/dd/yyyy) of actual or intended retirement: \_\_\_\_\_

Do you affirm that you will practice only as specified in Rule 64B5-7.007, Florida Administrative Code, if granted a limited license in Florida?  Yes  No

**List Place of Practice in Florida** – The director of the agency or institution must submit a letter of intention to employ. Section 456.015, Florida Statutes, requires that within 30 days of any change of employment, the department must be notified of the new address and place of employment.

Place of Employment	Address	Employment Setting
_____	_____	<input type="checkbox"/> Public or non-profit agency <input type="checkbox"/> Indigent of critical need population within the state

## 5. Criminal History

Have you ever been convicted of, or entered a plea of guilty, nolo contendere, or no contest to a crime in any jurisdiction other than a minor traffic offense? You must include all misdemeanors and felonies, even if adjudication was withheld by the court so that you would not have a record or conviction. Driving under the influence or driving while impaired is not a minor traffic offense for purposes of this question.  Yes  No

**If you answered "Yes" to the question above you are required to send the following items:**

- Self Explanation** describing in detail the circumstances surrounding each offense; including dates, city and state, charges and final results.
- Final Dispositions and Arrest Records** for all offenses. The Clerk of the Court in the arresting jurisdiction will provide you with these documents. Unavailability of these documents must come in the form of a letter from the Clerk of the Court.
- Completion of Sentence Documents.** You may obtain documents from the Department of Corrections. The report must include the start date, end date and that the conditions were met.

## 6. Criminal and Health Care 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 conviction falls into certain timeframes as established in Section 456.0635(2), Florida Statutes. If you answer YES to any of the following questions, please provide a written 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 below. Supporting documentation includes court dispositions or agency orders where applicable.

1. Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under Chapter 409, F.S. (relating to social and economic assistance), Chapter 817, F.S. (relating to fraudulent practices), Chapter 893, F.S. (relating to drug abuse prevention and control) or a similar felony offense(s) in another state or jurisdiction? **If "no", skip to #2.**  Yes  No
  - 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 10 years from the date of the plea, sentence and completion of any subsequent probation? (This question does not apply to felonies of the third degree under Section 893.13(6)(a), Florida Statutes).  Yes  No
  - c. **If "yes" to 1**, for the felonies of the third degree under Section 893.13(6)(a), Florida Statutes, has it been more than 5 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", please provide supporting documentation).  Yes  No
2. Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, 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)? **If "no", skip to #3.**  Yes  No
  - 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 Section 409.913, Florida Statutes? **If "no", skip to #4.**  Yes  No
  - 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? **If no, skip to #5.**  Yes  No
  - a. Have you been in good standing with a state Medicaid program for the most recent five years?  Yes  No
  - b. Did the termination occur at least 20 years prior to the date of this application?  Yes  No
5. Are you currently listed on the United States Department of Health and Human Services Office of Inspector General's List of Excluded Individuals and Entities?  Yes  No

**7. Applicant History – Professional Licensure** – If any below questions are answered “YES”, you must provide complete details as to state(s), license number(s), dates, and relevant circumstances on attached sheets.

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

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

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

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

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

**8. Statement of Financial Responsibility – Applicable to dentists only**

I have obtained and will maintain professional liability coverage in an amount of not less than \$100,000, with a minimum annual aggregate of not less than \$300,000, from an authorized insurer as defined under Section 624.09, F.S., from a surplus lines insurer as defined under Section 626.914(2), F.S., from a risk retention group as defined under Section 627.942, F.S., from the Joint Underwriting Association established under Section 627.351(4), F.S., or through a plan of self-insurance as provided in Section 627.357, F.S

I have obtained and will maintain an unexpired, irrevocable letter of credit, established pursuant to Chapter 675, F.S., in an amount of not less than \$100,000 per claim, with a minimum aggregate availability of credit not less than \$300,000.

I am exempt from demonstrating financial responsibility because I practice exclusively as an officer, employee or agent of the federal government, or of the state or its agencies or subdivisions.

I am exempt from demonstrating financial responsibility because I practice only in conjunction with my teaching duties at an accredited school or in its main teaching hospitals.

I am exempt from demonstrating financial responsibility because I do not practice in the State of Florida.

I am exempt from demonstrating financial responsibility because I have no malpractice exposure in the State of Florida.

**9. Drug Enforcement Administration Registration**

Are you registered with the DEA to prescribe controlled substances?  Yes  No

If yes, please provide your DEA number: \_\_\_\_\_

**10. Application Affidavit/Verification of Document**

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 limited licensure.

I hereby affirm that I have been licensed to practice the profession for which I now seek a limited license in a jurisdiction of the United States for at least 10 years. I affirm that I have retired from the practice of that profession and intend to practice only pursuant to the restrictions of the limited license. I understand that, once my limited license is granted, I may only practice in the employ of public agencies or institutions or nonprofit agencies or institutions which meet the requirements of s. 501(c)(3) of the Internal Revenue Code, and which provide professional liability coverage for my acts or omissions as the limited licensee. I also understand that, as a limited licensee, I may provide services only to the indigent or critical need populations within the state.

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 limited license to practice dentistry under Chapter 466, Florida Statutes, Chapter 456, Florida Statutes, and Chapter 64B5, Florida Administrative Code, in the State of Florida.

I hereby affirm that I have received, read and understood Chapter 466, Florida Statutes, Chapter 456, Florida Statutes, and Chapter 64B5, Florida Administrative Code, and acknowledge that I must abide by them.

Under penalties of perjury, I declare that I have read the foregoing Limited Licensure Application and that the facts stated in it are true.

Signature of Applicant: \_\_\_\_\_ Date: \_\_\_\_\_

# CONFIDENTIAL AND EXEMPT FROM PUBLIC RECORDS DISCLOSURE\*

<b>11. Name:</b>			<b>Social Security Number:</b>
_____	_____	_____	_____
Last	First	Middle	

\*Pursuant to 42 U.S.C. § 666(a)(13), the department is required and authorized to collect Social Security Numbers relating to applications for professional licensure. Additionally, section 456.013(1)(a), Florida Statutes, authorizes the collection of Social Security Numbers as part of the general licensing provisions. This information is exempt from public records disclosure.

**12. Applicant Health History** - If you answer "YES" to any of the following questions, you must submit a current mental health status report from a licensed mental health professional, wherein this professional practitioner opines that you are able to practice with reasonable skill and safety to patients or clients.

In the last 5 years, have you been enrolled in, required to enter into, or participated in any drug or alcohol recovery program or impaired practitioner program for treatment of drug or alcohol abuse that occurred within the past 5 years?  Yes  No

In the last 5 years, have you been admitted or referred to a hospital, facility or impaired practitioner program for treatment of a diagnosed mental disorder or impairment?  Yes  No

During the last 5 years, have you been treated for or had a recurrence of a diagnosed mental disorder that has impaired your ability to practice your profession within the past 5 years?  Yes  No

In the last 5 years, were you admitted or directed into a program for the treatment of a diagnosed substance-related (alcohol/drug) disorder or, if you were previously in such a program, did you suffer a relapse within the last 5 years?  Yes  No

During the last 5 years, have you been treated for or had a recurrence of a diagnosed substance-related (alcohol/drug) disorder that has impaired your ability to practice your profession within the past 5 years?  Yes  No

During the last 5 years, have you been treated for or had a recurrence of a diagnosed physical disorder that has impaired your ability to practice your profession?  Yes  No

**LIMITED LICENSE FEE WAIVER FORM**

**TO BE COMPLETED BY EMPLOYER OR VOLUNTEER  
DENTIST/DENTAL HYGIENIST**

Pursuant to Section 456.015, Florida Statutes and Rule 64B5-7.007, Florida Administrative Code, if a person applying for a limited license submits a notarized statement from the employing agency or institution stating that he/she will not receive monetary compensation for any services involving the practice of dentistry/dental hygiene, the licensure fees shall be waived.

***AFFIDAVIT***

I, \_\_\_\_\_, being first duly sworn, state that the following  
dentist/dental hygienist: \_\_\_\_\_  
(Type Or Print Dentist/Dental Hygienist's Name)

will NOT receive monetary compensation for any service involving the practice of dentistry/dental hygiene

from: Agency/Institution: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Signed: \_\_\_\_\_

Name (type or print): \_\_\_\_\_

Title: \_\_\_\_\_

STATE OF  
FLORIDA

COUNTY OF: \_\_\_\_\_

The above person is personally known to me or has produced \_\_\_\_\_ as  
identification.

SWORN AND SUBSCRIBED BEFORE ME  
THIS \_\_\_\_\_ DAY OF \_\_\_\_\_, \_\_\_\_\_  
(month) (year)

(SEAL)

NOTARY PUBLIC: \_\_\_\_\_

MY COMMISSION EXPIRES: \_\_\_\_\_