FLORIDA DEPARTMENT OF HEALTH
BOARD OF DENTISTRY

NON-PROFIT CORPORATION PERMIT APPLICATION

Applications will be accepted only if completed by an officer of the non-profit organization. Any questions not applicable must be indicated accordingly (N/A). Copies may be made by the non-profit organization as needed. This application is pursuant to Chapter 466.025(3), Florida Statutes and Rule 64B5-7.006, Florida Administrative Code. Please type or print.

PART I – PROFILE DATA

[1] Name of non-profit organization:		
[2] Mailing address:		
[3] Physical address:		
[4] Telephone: Primary ( )	Telephone: Secondary ( )	
[5] Name of officer of non-profit organization completing this application:	Name:	Title:
[6] Will you be utilizing non-Florida licensed dentist(s)?		YES NO
[7] If yes, provide name and date of birth of non-Florida licensed dentist. *Pages 3 and 4 must be completed by each non-Florida licensed dentist you intend to utilize. *Attach a copy of each applicant's current CPR card in basic life support, and certificates of completion of HIV/Aids & Domestic Violence from a Florida Board of Dentistry approved provider.*		
[8] NAME (Non-Florida Licensed Dentist):		Date of Birth:
[9] NAME (Non-Florida Licensed Dentist):		Date of Birth:
[10] NAME (Non-Florida Licensed Dentist):		Date of Birth:
[11] List the state(s) in which the non-Florida licensed dentist holds a license:		
[12] Indicate the name and license number of the supervising Florida licensed dentist:	NAME (Please Type or Print):	LICENSE NUMBER:
[13] I agree to provide general supervision to non-Florida licensed dentists employed by this organization. _____ Signature of Florida licensed dentist		_____ Date

Rule 64B5-7.006(2) requires the following:

1. Certified copy of your 501(c)(3) Registration with the Internal Revenue Service.
2. Justification for the employment of non-Florida licensed dentists.
3. "Plan of Operation" for the practice of the utilized dentist under the supervision of a Florida licensed dentist.

Non-Profit corporations providing care to the indigent must ALSO provide the following:

1. Statistics establishing only the treatment of indigent patients and/or
2. Admission criteria for indigent patients treated.
3. Description of the physical plant, available equipment and resources establishing the practice of minimum standard of dentistry at said facility. (i.e. floor space, number operatories, dental chairs, etc.).

Note: Individuals with a household income at or below 200% of the Federal Poverty Index shall be construed as indigent for the purpose of this application. Non-profit permit holders are required to operate as specified in Florida Statutes, Chapter 466.025(3) and Florida Administrative Code, Rule 64B5-7.006.

I declare under the penalty of perjury that the answers provided on this application are true and accurate. Furthermore, I certify on behalf of this non-profit organization that all copies are true reproductions of the original documents.

Signature of Director Date

PART II – PERSONAL AND LICENSURE HISTORY

NON-FLORIDA LICENSED DENTIST HISTORY – GENERAL (THE FOLLOWING SECTIONS ARE REQUIRED FOR EACH NON-FLORIDA LICENSED DENTIST; ATTACH ADDITIONAL SHEETS IF NECESSARY)

NAME:_____

ALL OF THE FOLLOWING QUESTIONS MUST BE ANSWERED. If you answer "YES" to ANY of the following questions, explain in full by addendum to the application. You must make a statement that includes, but is not limited to, the date(s), location(s), specific circumstances, practitioners and/or treatment involved, etc., pertaining to the "YES" answer. Any "YES" answer must be substantiated by either official documents sent directly to the board office from the respective state licensing board or official copies of court records. A "YES" answer is NOT an automatic cause for denial of licensure. *NOTE: Obtaining or attempting to obtain a license by bribery, fraud, or knowing misrepresentation is a violation of the Dental Practice Act and may result in the denial of licensure, suspension or revocation of license, and/or other penalty under section 466.028, Florida Statutes, or Rule Chapter 64B5-13, F.A.C.*	
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. If yes, please list date, jurisdiction (state and county), offense, disposition, and all other relevant information On reverse side or an attached sheet	YES NO
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 you responded "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)?	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", do not answer 3a.)**	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, do not answer 4a or 4b)**	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
6. If "yes" to any of the questions 1 through 5 above, on or before July 1, 2009, were you enrolled in an educational or training program in the profession in which you are seeking licensure that was recognized by this profession's licensing board or the Department of Health? (If "yes", please provide official documentation verifying your enrollment status.)	YES NO
7. Have you ever been denied the right to take a Dental or any other licensure examination in any state?	YES NO
8. Have you ever been refused a license to practice Dentistry or any other license or the renewal thereof in any state?	YES NO
9. Have you ever had a license revoked or a certificate of registration to practice Dentistry 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
10. 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
11 Is there currently pending against you in any jurisdiction a complaint against your professional conduct or competence as a Dentist or other licensed professional? • If Questions 7-11 above are answered "YES", you must provide complete details as to state(s), license number(s), dates, and relevant circumstances on reverse side or on attached sheets.	YES NO

PART III – APPLICANT LICENSURE STATUS

[1]a. Do you now hold or have you ever held a license to practice Dentistry or healthcare profession in any state, U.S. territory or foreign country? (List most recent first) • If "YES", list ALL such licenses below	YES NO

[1]b. State:	[1]c. License #:	[1]d. If license is not in force, how and when was validity ceased?

[2] Do you have any applications for Dental or Dental Hygiene Licensure currently pending in any state or foreign country? • If "YES", list ALL such state or jurisdictions below	YES NO

PART IV - APPLICANT RELEASE AND AFFIDAVIT

THE FOLLOWING STATEMENT MUST BE COMPLETED:

APPLICANT RELEASE AND AFFIDAVIT:

I,_____, state that I am the person referred to in the foregoing Non-Profit 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 the Non-Profit Permit application.

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 the Non-Profit Permit 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.

Signature of applicant _____ **Date _____**

CONFIDENTIAL AND EXEMPT FROM PUBLIC RECORDS DISCLOSURE

FLORIDA DEPARTMENT OF HEALTH
BOARD OF DENTISTRY

This page is exempt from public records disclosure. The Department of Health is required and authorized to collect Social Security Numbers relating to applications for professional licensure pursuant to Title 42 USCS s. 666(a)(13). For all professions regulated under chapter 456, Florida Statutes, the collection of Social Security Numbers is required by section 456.013(1)(a), Florida Statutes.

Name: _____
Last First Middle

Social Security Number: _____

PART V - APPLICANT HISTORY - HEALTH

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.	
A. 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
B. 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
C. 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
D. 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
E. 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
F. 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