South Carolina Department of Labor, Licensing and Regulation
South Carolina Board of Dentistry
P.O. Box 11329 • Columbia, SC 29211
Phone: 803-896-4599
www.llr.state.sc.us/POL/dentistry

RESTRICTED VOLUNTEER REQUIREMENTS AND INSTRUCTIONS

The licensure process may take from 6-8 weeks. Applications are processed in the order they are received.

Before calling in to the Board Office - You may check your application status online at: www.llr.state.sc.us/pol/dentistry and select Application Status.

Basis for Licensure:

1. Applicant must have graduated from a dental or dental hygiene program accredited by the American Dental Association (ADA).

2. Applicant must have at least five (5) years of clinical practice as a dentist or dental hygienist.

   If applicant has NOT actively practiced dentistry (or dental hygiene) within the past five (5) years, applicant must:

   - Submit a physician's statement of mental and physical competency verifying that the applicant is able to practice dentistry/dental hygiene with reasonable skill and safety to patients.
   - Provide two (2) letters attesting to the applicant's good moral character, from dental professionals, on the signator's letterhead. The letters must be original and dated within the last year.
   - Provide proof of completion of an infection control course, approved by the Board, within the past two (2) years.
   - If requested by the Board, appear for a personal interview.
   - If requested by the Board, take a refresher course or passage of an examination administered by the Board or a testing agency designated and approved by the Board.

3. A notarized statement from the Program Director of an approved clinic verifying applicant's employment as a volunteer must be submitted to the Board's office. Statute reference for clinics: 40-15-177.

4. Applicant must provide verification (photocopy) of their current cardiopulmonary resuscitation certification (CPR).

5. **National Practitioner Data Bank:** Applicants licensed to practice dentistry or dental hygiene in another state must request a report (self-query) from the National Practitioner Data Bank. Contact the NPDB at: www.npdb-hipdb.com or 1-800-767-6732. You may submit this report with your application.

6. **License Verifications:** Contact each state board you are currently or have previously been licensed with and have the license verification mailed directly to the Board office at the above address. We will accept a state board issued form.

7. **Jurisprudence Examination:** Once our office receives your application and fee, you will be e-mailed instructions with a UserId and Password to take the exam online in 6-8 weeks. A score of 70 or higher is considered a passing score. Do not send in your certificate of passing, the Board is automatically notified.

   To prepare for the Jurisprudence exam, you should review the Dental Laws and Regulations located on the website under Laws/Policies. http://llr.sc.gov/POL/Dentistry/index.asp?file=laws.htm

8. Applicant must not have failed a Regional or corresponding state clinical dental or dental hygiene examination within the past five (5) years.

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APPLICATION FOR RESTRICTED VOLUNTEER

Include with your application:

- Notarized Verification of Lawful Presence
- Copy of drivers license, state issued ID or Passport
- A 2"x2" passport style photo taken within the last 6 months
- Legal documentation for name change (marriage cert, divorce decree, court order, etc), if applicable
- Copy of Social Security Card
- Notarized statement from Program Director at Clinic
- Copy of current CPR card
- National Practitioner Data Bank Report
- 2 Letters of Recommendation, if applicable

I HEREBY MAKE APPLICATION FOR:

☐ Restricted Volunteer Dental License ☐ Restricted Volunteer Dental Hygiene License
☐ Restricted Volunteer Specialist

CLINIC INFORMATION:

Complete the name and address of the clinic in which you are seeking employment. A notarized statement from the Program Director of the clinic verifying your employment as a volunteer must be submitted to the Board's office.

_____ _____
Clinic Name Complete Address

APPLICANT INFORMATION:

Name: _____ Maiden: _____
(Last, First, Middle, and Suffix)

Preferred Mailing Address: _____
(Street/PO BOX, City, State, Zip)

Home Address: _____
(Street, City, State, Zip)

Phone: _____ Cell Phone: _____ Business Phone: _____

Email Address: _____

Social Security Number: _____ Date of Birth: _____

For Statistical Purposes only: Place of Birth (City, State): _____

Gender: ☐ Female ☐ Male

Have you ever legally changed your name including marriage or divorce? Yes ☐ No ☐
If yes, you are required to enclose a copy of the legal document indicating the official change.

Do you need special accommodations in order to take an exam? Yes ☐ No ☐

1. Are you a Diplomate of a national certifying specialty board recognized by the American Dental Association?

Yes ☐ No ☐

2. Do you have at least five (5) years of active clinical practice in the field for which you are seeking licensure?

Yes ☐ No ☐

3. Have you been in the active clinical practice of dentistry / dental hygiene within the past five (5) years?

Yes ☐ No ☐

DENTAL / DENTAL HYGIENE EDUCATION INFORMATION:

Dental College/Institution must be approved by Commission on Accreditation of Dental and Dental Auxiliary programs of ADA.

Name of School	LOCATION (City and State or Country)	GRADUATION DATE	DEGREE
Dental / Dental Hygiene School			

POST-GRADUATE EDUCATION INFORMATION

List chronologically all dental related post-graduate education and training (internship, residency, fellowship or other program) Attach an additional sheet if needed.

Institution/Program	Type of Training

RECORD OF LICENSURE:

List all states in which you have been licensed in; regardless of status: Active, Inactive, Expired, etc. You will need to contact each State Board and request a License Verification to be mailed directly to our Board at the above listed address. We will accept a state board issued form. Attach an additional sheet if needed.

STATE	DATE OF LICENSURE	LICENSE NO.	EXPIRATION DATE	BASIS FOR LICENSURE (State Exam, Regional Exam, National Exam, Credentials)

DENTAL PRACTICE HISTORY:

List all activities relating to dentistry/dental hygiene chronologically since post-graduate training. Explain any intervals where you were not in training or practicing dentistry. Attach additional sheet if necessary.

FROM Month / Yr	TO Month / Yr	DENTIST / EMPLOYER NAME	OFFICE ADDRESS & LOCATION	TYPE OF PRACTICE General Dentistry / Specialty	# HRS. / WEEK

PERSONAL HISTORY INFORMATION:

Please answer all questions. You must attach a written explanation for any "Yes" answers.

1. Have you ever had an application for a license / certificate in any health care profession refused or denied by any dental licensing board, health care facility or other entity?
   YES ☐ NO ☐
2. Have you ever had any written complaint, formal accusation, final order, disciplinary action or consent order filed against you by any person, jurisdiction, health care facility or dental board?
   YES ☐ NO ☐
3. Have you ever had a malpractice lawsuit or judgment filed against you? YES ☐ NO ☐
4. Have you ever been convicted, pled guilty or pled nolo contendere for violation of any federal, state, or local law (you may exclude minor traffic violations, juvenile and/or expunged violations)?
   YES ☐ NO ☐
5. Are you currently under investigation or the subject of pending disciplinary action by any dental licensing board, health care facility or other entity?
   YES ☐ NO ☐
6. Currently or within the last two years, have you developed or been treated for any physical, mental, or emotional condition or a drug or alcohol addiction that might interfere with your ability to competently and safely perform the essential functions of practice?
   YES ☐ NO ☐
7. **Dentist/Specialist Only:**
   Have you ever voluntarily surrendered your license, control substance registration or DEA registration?
   YES ☐ NO ☐

Dentist/Specialist Only:

8. Have you ever had your ability to prescribe controlled substances denied, revoked, suspended or limited by any hospital, health care facility or other entity?
   YES ☐ NO ☐

REFERENCES:

List two (2) dental professionals' names and their contact information who are writing letters of recommendations in support of your SC license application. You may submit these with your application. This is **only** needed if you have not actively practiced in the past five (5) years.

Dentist Name	Dentist's Address	Dentist's Phone Number

PRIVACY DISCLOSURE:

South Carolina Law requires that every individual who applies for an occupational or professional license provide a social security number for use in the establishment, enforcement and collection of child support obligations and for reporting to certain databanks established by law. Failure to provide your social security number for these mandatory purposes will result in the denial of your licensure application. Social security numbers may also be disclosed to other governmental regulatory agencies and for identification purposes to testing providers and organizations involved in professional regulation. Your social security number will not be released for any other purpose not provided for by law.

Other personal information collected by the Department for the licensing boards it administers is limited to such personal information as is necessary to fulfill a legitimate public purpose. The South Carolina Freedom of Information Act ensures that the public has a right to access appropriate records and information possessed by a government agency. Therefore, some personal information on the application may be subject to public scrutiny or release. The Department collects and disseminates personal information in compliance with The South Carolina Freedom of Information Act, the South Carolina Family Privacy Protection Act, and other applicable privacy laws and regulations. Additionally, the Department shares certain information on the application with other governmental agencies for various governmental purposes, including research and statistical services.

NOTE:

Your application is good for one (1) year from the date of receipt. If all required information is not received within this one (1) year period; you must begin the application process from the beginning. This includes, but is not limited to, the application fee, transcripts, license verifications, etc.

AFFIDAVIT AND RELEASE OF APPLICANT:

I, _____, of _____, being duly sworn
(Applicant's Name) *(City, State)*
and identified, of good moral character, and as the person referred to in this application and signed photo, attest to the truth of each statement made in said Application. I further swear that I have read and understand the law and the Rules and Regulations, regarding the practice of my profession, which are posted on the Board's Internet site and/or were provided to me by the Board office, and agree to abide by them in the practice of dentistry in the State of South Carolina.

I HEREBY:

SIGNIFY my willingness to appear to answer such questions as the Board may find necessary, which may include a full Board interview.

RELEASE to the Board, its staff, and their representatives, any and all documentation necessary now and in the future to establish my physical and mental capabilities to render competent dental care including, but not limited to, requiring substance abuse testing or proof that no physical or psychological impairment exists that would adversely affect my ability to practice dentistry with reasonable skill and safety.

AUTHORIZE the Board, its staff, and their representatives to conduct a criminal background investigation, consult with my prior and current associates and others who may have information bearing on my professional competence, character, health status, ethical qualifications, ability to work cooperatively with others, and other qualifications.

RELEASE from liability the Board, its staff, and all their representatives and any and all organizations which provide information for their acts performed and statements made in good faith and without malice concerning my competence, ethics, character, and other qualifications for certification.

ACKNOWLEDGE that I, as an applicant for licensure, have the burden of producing adequate information for a proper evaluation of my professional, ethical, other qualifications, and for resolving any doubts about such qualifications.

AUTHORIZE release, use and disclosure of otherwise HIPPA protected health information to the limited extent necessary for my application to receive full consideration up to and including discussion in a public forum should that become necessary.

I, _____, hereby certify that I will limit my practice of dentistry exclusively to the patients receiving service from _____ which is an organization approved by the Board and that such practice is without compensation.

THIS CERTIFIES THAT THE INFORMATION SUBMITTED BY ME IN THIS APPLICATION IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

_____ _____
SIGNATURE OF APPLICANT **DATE**

Sworn to before me this ____ day of_____, 20 ___

_____
Notary Signature

_____
Print Name
Notary Public for the State of: _____

My Commission Expires: _____

Attach Photo Here

Tape a passport-type photograph taken within the last six (6) months.

STATE OF SOUTH CAROLINA
DEPARTMENT OF LABOR, LICENSING AND REGULATION

VERIFICATION OF LAWFUL PRESENCE IN THE UNITED STATES
AFFIDAVIT OF ELIGIBILITY

Pursuant to Section 8-29-10, *et seq.* of the South Carolina Code of Laws (1976, as amended), the Department of Labor, Licensing and Regulation must verify that any person who applies for a South Carolina license is lawfully present in the United States. Complete and sign this affidavit of eligibility. The information provided is subject to verification.

Section A: LAWFUL PRESENCE in the United States.

The undersigned _____, of _____
(Print clearly First, Middle, and Last name) (Home Address, City, State, and Zip Code)
being first duly sworn deposes and states as follows:

Check only one box:

1. ☐ I am a United States citizen; or
2. ☐ I am a Legal Permanent Resident of the United States eighteen years of age or older; or
3. ☐ I am a Qualified Alien or non-immigrant under the Federal Immigration and Nationality Act, Public Law 82-414, eighteen years of age or older, and lawfully present in the United States.
4. ☐ Other:_____Please submit any documentation that supports this status.

Date of Birth: _____

Alien Number:_____ I-94 Number: _____

(**If you checked number 2, 3, or 4 you must attach a copy of your immigration documents**. See instruction sheet for a list of accepted immigration documents.)

Section B: ATTESTATION.

I understand that in accordance with section 8-29-10 of the South Carolina Code of Laws, a person who knowingly and willfully makes a false, fictitious, or fraudulent statement or representation in an affidavit shall, in addition to other sanctions imposed by this State or the United States, be guilty of a felony, and upon conviction must be fined and/or imprisoned for not more than 5 years (or both).

I understand that the representations made in this Affidavit shall apply through any license(s) or renewals issued, and that I shall have an affirmative duty to immediately advise the Department of Labor, Licensing and Regulation of any change of my immigration or citizenship status.

I swear and attest the information contained herein is true and correct to the best of my knowledge. I understand that under South Carolina law, providing false information is grounds for denial, suspension, or revocation of a license, certificate, registration or permit.

_____
Signature of Affiant

SWORN to before me this_____day of_____, 20_____

_____
Notary Signature

_____
Print Name

Notary Public for _____

My Commission Expires: _____

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INSTRUCTION SHEET FOR COMPLETING AFFIDAVIT OF ELIGIBILITY

CHECK box 1:
If you are a United States Citizen by birth or naturalization

CHECK box 2:
If you are a Legal Permanent Resident and you are not a U.S. Citizen, but are residing in the U.S. under legally recognized and lawfully recorded permanent residence as an immigrant.
PROVIDE A COPY OF ALL IMMIGRATION DOCUMENTS.

CHECK box 3:
If you are a Qualified Alien. You are a Qualified Alien if you are:
An alien who is lawfully admitted for residence under the INA.
An alien who is granted asylum under Section 208 of the INA.
A refugee who is admitted to the United States under Section 207 of the INA.
An alien who is paroled into the United States under Section 212(d)(5) of the INA for a period of at least 1 year.
An alien whose deportation is being withheld under Section 243(h) of the INA (as in effect prior to April 1, 1997) or whose removal has been withheld under Section 241(b)(3).
An alien who is granted conditional entry pursuant to Section 203(a)(7) of the INA as in effect prior to April 1, 1980.
An alien who is a Cuban/Haitian Entrant as defined by Section 501(e) of the Refugee Education Assistance Act of 1980.
An alien who has been battered or subjected to extreme cruelty, or whose child or parent has been battered or subject to extreme cruelty.
PROVIDE A COPY OF ALL IMMIGRATION DOCUMENTS.

ACCEPTED IMMIGRATION DOCUMENTS:
Unexpired Reentry Permit (I-327)
Permanent Resident Card or Alien Registration Receipt Card With Photograph (I-551)
Unexpired Refugee Travel Document (I-571)
Unexpired Employment Authorization Card Which Contains a Photograph (I-766)
Machine Readable Immigrant Visa (with Temporary I-551 Language)
Temporary I-551 Stamp (on passport or I-94)
I-94 (Arrival/Departure Record) in Unexpired Foreign Passport
I-20 (Certificate of Eligibility for Nonimmigrant, F-1, Student Status)
DS2019 (Certificate of Eligibility for Exchange Visitor, J-1, Status)