STATE OF TENNESSEE
DEPARTMENT OF HEALTH
DIVISION OF HEALTH LICENSURE AND REGULATION
OFFICE OF HEALTH RELATED BOARDS
665 MAINSTREAM DRIVE
NASHVILLE, TENNESSEE 37243

TENNESSEE BOARD OF DENTISTRY
(615) 532-5073 or 1-800-778-4123
http://tn.gov/health/topic/Dentistry-board

LIMITED AND LIMITED EDUCATIONAL LICENSURE REQUIREMENTS FOR DENTIST

A Limited Educational License is provided to applicants who are faculty members in Dental and Dentist Institutions. This license allows practice only under the auspices of the educational institution and does not permit private practice. Once a licensee is no longer employed by the educational institution, the license to practice in Tennessee will be terminated.

A Limited License is provided to applicants who are practicing in ADA accredited institutions, or dental education programs, or in federally-designated health professional shortage areas. This license does not allow private practice outside of the institution, program or shortage area. Once a licensee is no longer employed by the educational institution, program or working in federally-designated health professional shortage area, the license to practice in Tennessee will be terminated.

I. THE APPLICATION PROCESS

Application, practice, and renewal as a dentist are governed by T.C.A. § 63-5-101, et seq. and Rules 0460-1-.01, et seq.

1. All **application fees are non-refundable.**
2. All documents and fees required to be submitted by you, or which must be requested from the appropriate institutions in the application process, must be mailed directly to:

Tennessee Board of Dentistry
665 Mainstream Drive
Nashville, TN 37243

3. Allow fourteen (14) working days for information mailed to our Office to be received and placed in your file. Federal Express or special courier services will not reduce the processing time. Additionally, if Federal Express or special courier services are used, you will be responsible for charges incurred.
4. If the application is not complete upon receipt by the Board's Administrative Office, a deficiency letter will be sent to you by certified mail. The supporting documentation requested in the letter must be received in the Board's Administrative Office within sixty (60) days from the date of the initial deficiency letter. **Files not completed within sixty 60) days will be closed**.
5. It is recommended that you do **NOT** set a specific date to begin practice as a dentist in Tennessee until you are granted a license by the Tennessee Board of Dentistry.
6. **IT'S THE LAW!** If you change your mailing address, you must notify the Board's Administrative Office, in **writing,** within thirty (30) days. Failure to abide by this law could affect your license, since failure to receive the renewal application does not relieve you of the responsibility for timely renewal.
7. ANSWER ALL QUESTIONS ON THE APPLICATION. DO NOT LEAVE ANY AREA BLANK. RESPOND "NOT APPLICABLE" or (N/A) TO ALL QUESTIONS THAT DO NOT APPLY!

IMPORTANT: You must have a license issued by the Tennessee Board of Dentistry before you may lawfully teach or practice as a Dentist in Tennessee.

II. CHECKLIST – USE TO COMPLETE YOUR APPLICATION

NOTE: All submissions must be executed and dated less than one (1) year before receipt, or the documents will be rejected by the Board.

Done

1. Tape to the first page of the application a passport-size photograph of yourself (taken within the last twelve (12) months); then sign the front of the photograph. ___

2. Complete pages 1 through 6 of the application. Sign page 6 of the application in the presence of a Notary; then, mail all six (6) pages to the Board's Office. ___

3. **Paperclip a check or money order in the amount of One Hundred Sixty Dollars ($160) made payable to the "Board of Dentistry" to the front of the Application.** ___

4. Request from the educational institution which you completed your D.D.S. or D.M.D or equivalent degree that an official transcript be mailed directly to the Board of Dentistry. ___

5. If the educational institution you attended is not ADA accredited, a "Course-By-Course Evaluation Report" must be submitted directly from Educational Credential Evaluators, Inc. (www.ece.org) indicating that you have successfully completed the equivalent of four (4) years of study in a dentistry program in the United States. ___

6. **If applying for a Limited License**, request from the educational institution from which you completed your ADA accredited specialty program that certification of successful completion be mailed directly to the Board of Dentistry. ___

7. If you **are** or **have ever been** licensed, certified, registered, or permitted by any state to practice as a dentist (or any other health care professional), you must request a verification from each and every state. The verification must be mailed directly to the Board's Office from the other state(s). ___

NOTE: Dentists applying for a **Limited Educational License** are required to have held an active license in another state for at least one year prior to submitting an application.

8. **If applying for a Limited License:** Request to have your National Board scores forwarded directly to the Board of Dentistry. There is a fee for duplicate scores. The scores can be requested at http://www.ada.org/en/jcnde or by contacting the Joint Commission on National Dental Examinations · 211 East Chicago Avenue, Suite 600 · Chicago, IL 60611-2637 · 800-232-1694. ___

9. Submit two (2) **Original** letters of recommendation from licensed dentist who can attest to your good moral character. These letters must identify the individual(s) as a licensed dentist, be submitted on letterhead, and bear the original signature of the author. ___

10. **If applying for a Limited Educational License**, you must submit a letter of recommendation from the Dean or Director of the dental educational institution and a copy of the contract employing you as a faculty member at the institution. ___

11. **If applying for a Limited License**, you must submit either a letter of recommendation from the Dean or Director of the dental educational institution and a copy of the contract employing you as a faculty member at the institution **or** proof of employment as a dentist or proof of starting/maintaining a private dental practice in a federally-designated health professional shortage area. ___

12. Copy the front and back of your current CPR card on a full-sized sheet of paper. The CPR certification must comply with the Board's *Policy: Cardiopulmonary Resuscitation (CPR) Requirements For Dentists, Dental Hygienists, And Dental Assistants* which requires completion of a BLS Healthcare Provider course, or CPR/AED for the Professional Rescuer, or an equivalent course, which provides training for healthcare professionals in CPR and the use of an AED. The course must be conducted in person and include a skills examination on a manikin with a certified instructor. ___

13. Attach proof of U.S. or Canadian citizenship or evidence of being legally entitled to live and work in the U.S. (e.g. copy of birth certificate, voter's registration card, naturalization papers, or current visa status.) If not a U.S. or Canadian citizen, the front and back of the passport, valid visa, I-94 and Form I-766 must be submitted. ___

14. Please read the instructions on page 4 of the application carefully. You must answer "Yes","No",or "N/A" to **every** question. **If any of your answers to the "competency questions" on pages 4 and 5 of the application were in the affirmative, please submit a separate document to explain the situation.** In addition to your explanation, the final documents or orders from the issuing states, courts and/or agencies must be submitted. ___

15. If you took the Southern Regional Testing Agency (SRTA), North East Regional Board of Dental Examiners (NERB), Western Regional Examining Board (WREB), Central Regional Dental Testing Service (CRDTS) examination or any other Board-approved examination, you will need to request that the testing agency send proof of your passing scores directly to the Board's Administrative office. ___

16. Applicants who have failed three (3) times the National Board or any regional examination must successfully complete a remedial course of post-graduate studies at a school accredited by the ADA before consideration for licensure by the Board. The program director of the post-graduate program must provide written documentation of the content of such course and certify successful completion. ___

17. **A criminal background check is required.** For instructions to obtain a criminal background check, go to http://tn.gov/health/article/CBC-instructions. ___

18. Complete and submit along with your application the *Practitioner Profile Questionnaire* which is online at http://tn.gov/assets/entities/health/attachments/PH-3585.pdf. You are required by law update your profile within 30 days of any change as long as you have an active license. Failure to do so may subject you to disciplinary action. ___

19. All applicants must complete, sign and have notarized the Declaration of Citizenship form and submit the documents required. The Declaration is online at http://tn.gov/assets/entities/health/attachments/PH-4183.pdf.. ___

Additional certifications or permits that you can submit an application to add to your Limited or Limited Educational license, if you qualify (see Rules 0460-2-.06 and/or 0460-2-.07):

1. Specialty certification
2. Limited Conscious Sedation Permit
3. Comprehensive Conscious Sedation Permit
4. Deep Sedation/General Anesthesia Permit

TAPE A CURRENT, FULL-FACE PHOTOGRAPH

(SIGNED BY APPLICANT ON THE FRONT OF THE PHOTO) HERE

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FOR OFFICIAL USE ONLY

FEES IF APPLYING FOR A LIMITED OR LIMITED EDUCATIONAL LICENSURE

1201-001	$ 150
1201-006	$ 10
	$ 160

APPLICATION FOR LIMITED OR LIMITED EDUCATIONAL LICENSURE

Check Licensure Method:

_____ Limited License _____ Limited Educational License

Please complete each question and return the application, supporting documents, and the One Hundred Sixty Dollars ($160) application fee to the above address.

PERSONAL INFORMATION

PLEASE PRINT IN INK

Name: _____
Last First Middle Maiden (if not used as your middle name)

Social Security Number*: _____ U.S. Citizen: Yes ___ No____
All applicants must complete the Declaration of Citizenship form

Date of Birth: _____ Place of Birth: _____

Mailing Address: _____

_____ Zip _____

Practice Address**: _____

_____

_____ Zip _____

E-mail address: _____

Do you wish to receive notification, including renewal notification, from the Department of Health via email? ___Yes ___ No

County (TN Applicants Only): _____ Phone: Home: _____

Gender: (optional-for statistical purposes only) Office: _____

Female _____ Male _____

Have you ever been known by any other names besides what is listed above? Yes ____ No _____

If yes, please state in full every other name by which you have been known, the reason therefore, and inclusive dates so known: _____

_____

***You must put your social security number on this form for the application to be complete. State law requires social security numbers on this application. Tenn.Code. Ann. § 36-5-1301(a), as authorized by 42 U.S.C. § 405(c)(2)(C)(i). The number will be used to verify your identity and for any other purpose allowed by state or federal law.**

****If you have no practice address, notify the Board of your practice address within 30 days of obtaining a practice address. If you have multiple practice address, please attach an additional page listing all practice addresses.**

EDUCATIONAL AND EMPLOYMENT INFORMATION

Please provide the following information for all educational institutions you have attended beyond high school. Use the back of this page if you need additional space. Request an official transcript be submitted directly from the educational institution where you completed your dental program.

From: Mo./Yr.	To: Mo./Yr.	Educational Institution	City, State	Degree Earned	Year Graduated

Please complete your entire employment history starting with the most current position first. Use the back of this page, if you need additional space. Dates of employment must be included.

Company/ Employer:	Address: (Street, City, and State)	Position:	Duties:	Dates From: Mo./Yr.	Dates To: Mo./Yr.

CERTIFICATION INFORMATION

List below **ALL STATES, COUNTRIES, OR PROVINCES IN WHICH YOU HAVE EVER BEEN OR ARE CURRENTLY LICENSED, PERMITTED, OR CERTIFIED** as a Dentist. Additional pages may be added if necessary. **If this section does not apply, mark N/A.** Request that verification of licensure be submitted directly to the Board's Office from each state.

STATE	LICENSE NUMBER	DATE ISSUED	CURRENT STATUS

List below **ALL** states, countries, or provinces in which you hold or have ever held a license, certification, or permit as a health professional other than a Dentist. Additional pages may be added if necessary. **If this section does not apply, mark N/A.** Request that verification of licensure be submitted directly to the Board's Office from each state.

STATE	PROFESSION	LICENSE NUMBER	DATE ISSUED	CURRENT STATUS

		YES	NO
1.	Have you taken the National Boards exam?		
2.	Have you ever previously applied for a dentist, dental hygiene, or dental assisting license in Tennessee?		
3.	Have you ever taken the Southern Regional Testing Agency (S.R.T.A.) exam?		
4.	Have you ever taken the North East Regional Board (NERB) exam?		
5.	Have you ever taken the Western Regional Examining Board (WREB) exam?		
6.	Have you ever taken the Central Regional Dental Testing Service (CRDTS) exam?		
7.	Have you ever taken the Council of Interstate Testing Agency (CITA) exam?		
8.	Have you ever taken a state licensure examination?		

Regional or State Exam(s) Taken: _____

Exam Site(s): _____

Date Exam(s) Taken: _____

COMPETENCY INFORMATION

PLEASE ANSWER THE FOLLOWING QUESTIONS. If any answers to the questions in this part are in the **affirmative**, attach an explanation on a separate sheet. ***In support of your explanation, the final documents or orders from the issuing states, courts, and/or agencies must be submitted along with this application*. Please respond to ALL questions.**

For the purposes of these questions, the following phrases or words have the following meanings:

1. **"Ability to practice your profession"** is to be construed to include all of the following:
   a. The cognitive capacity to make appropriate clinical diagnosis (if necessary), exercise reasoned judgments, to learn, and keep abreast of developments in your profession;
   b. The ability to communicate those judgments and information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
   c. The physical capability to perform tasks and procedures required of your profession, with or without the use of aids or devices, such as corrective lenses or hearing aids.
2. **"Medical condition"** includes physiological, mental or psychological conditions or disorders, such as, but not limited to; orthopedic, visual, speech and/or hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disability, HIV disease, tuberculosis, drug addiction, and alcoholism.
3. **"Chemical substances"** is to be construed to include alcohol, drugs, or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.
4. **"Currently"** does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather, it means recently enough so that the use of drugs or alcohol may have an ongoing impact on one's functioning as a licensee or within the past two (2) years.
5. **"Illegal use of controlled substances"** means the use of controlled substances obtained illegally (e.g. heroin, or cocaine) as well as the use of controlled substances which are not obtained pursuant to a valid prescription or not taken in accordance with the directions of a licensed health care practitioner.

QUESTIONS: Please respond to ALL questions. If you answer "YES" to any question, please attach a written explanation.	**YES**	**NO**
1. Do you currently have a medical condition which in any way impairs or limits your ability to practice dentistry with reasonable skill and safety?	____	____
a. If yes, are they reduced or ameliorated because you receive ongoing treatment (with or without medications) or participate in a monitoring program?	____	____
b. If you have any limitations or impairments caused by an existing medical condition, are they reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice?	____	____
2. Do you currently use chemical substances?	____	____
If yes, do they in any way impair or limit your ability to practice dentistry with reasonable skill and safety?	____	____

[If you receive such ongoing treatment or participate in such a monitoring program, the Board will make an individual assessment of the nature, the severity, and the duration of the risks associated with an ongoing medical condition so as to determine whether an unrestricted license should be issued, whether conditions should be imposed, or whether you are or are not eligible for licensure.]

COMPETENCY INFORMATION
(continued)

QUESTIONS: Please respond to ALL questions. If you answer "YES" to any question, please attach a written explanation.	**YES**	**NO**
3. Are you currently engaged in the illegal use of controlled substances?	___	___
If yes, are you currently participating in a supervised rehabilitation program or professional assistance program that monitors you in order to assure that you are not engaged in the illegal use of controlled substances?	___	___
4. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, or voyeurism?	___	___
5. If you have held or applied for a license or certificate to practice as a Dentist in any state, country, or province, has, it been, or was it ever, denied, reprimanded, suspended, restricted, revoked, otherwise disciplined, curtailed, or voluntarily surrendered under threat of investigation or disciplinary action?	___	___
6. If you have ever had staff privileges at any hospital or health care facility, have they ever been revoked, suspended, curtailed, restricted, limited, otherwise disciplined, or voluntarily surrendered under threat of restriction or disciplinary action?	___	___
7. Have you ever failed a dental examination? (National Boards, regional or state) If yes, which exam and how may times have you failed? _____	___	___
8. Have you ever been convicted of a felony or a misdemeanor other than a minor traffic offense?	___	___
9. Have you ever applied for and been denied a state or federal controlled substance certificate?	___	___
10. If you have possessed such a certificate, has the certificate ever been revoked, suspended, restricted, otherwise disciplined, or voluntarily surrendered under threat of investigation or disciplinary action?	___	___
11. Have you ever been rejected or censured by a dental society?	___	___
12. In relation to the performance of your professional services in any profession:		
a. Have you ever had a final judgment rendered <u>against</u> you;	___	___
b. Have you ever entered into a settlement or had any legal, adverse action brought <u>against</u> you; or	___	___
c. Are there any legal actions pending <u>against</u> you or to which you are a party?	___	___
13. If you have ever held a license or certificate in ANY health care profession, has it ever been reprimanded, suspended, restricted, revoked, otherwise disciplined, curtailed, or voluntarily surrendered under threat of investigation or disciplinary action?	___	___
14. Are you currently being treated for the addiction to alcohol or drugs?	___	___
15. Are you currently being treated for a psychological condition?	___	___
16. Have you ever been dropped, suspended, expelled, or disciplined by any school or college for any cause?	___	___

APPLICANT: FILL OUT THE FOLLOWING AFFIDAVIT IN THE PRESENCE OF A NOTARY PUBLIC

AFFIDAVIT AND RELEASE

I, _____, of _____,
(Applicant's Name) *(City)* *(State)*
being duly sworn and identified as the person referred to in this application attests 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 as a dental assistant in the State of Tennessee.

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 safely practice as a dental assistant.

AUTHORIZE the Board, its staff, and their representatives to 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 the malice concerning my competence, ethics, character, 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, and other qualifications, and for resolving any doubts about such qualifications.

AUTHORIZE release, use and disclosure of otherwise HIPAA 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.

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

_____ _____
SIGNATURE **DATE**

Sworn to before me this _____ day of _____, _____.

_____ Affix Seal Here
NOTARY PUBLIC

My Commission Expires _____