New Jersey Office of the Attorney General
Division of Consumer Affairs
New Jersey State Board of Dentistry
124 Halsey Street, 6th Floor, P.O. Box 45005
Newark, New Jersey 07101
(973) 504-6405

Dental Assistant Application Checklist

There are 3 ways to obtain a license as a dental assistant in the State of New Jersey.

1. Successfully complete an educational program for dental assistants approved by the Commission on Accreditation within the last ten years and successfully complete the Registered Dental Assistant Examination administered by the Dental Assisting National Board (DANB) within ten years prior to the date of application; or

2. Obtain at least two years of work experience as a dental assistant within five years from the date of application; pass the Registered Dental Assistant Examination administered by the Dental Assisting National Board (DANB) within ten years of the date of application; successfully complete a Board-approved program in expanded functions; and pass the New Jersey Expanded Functions Examination administered by DANB; or

3. Obtain at least two years of work experience as a dental assistant within five years from the date of application; pass the Registered Dental Assistant Examination administered by DANB within ten years prior to application; and successfully pass (challenge) the New Jersey Expanded Functions Examination administered by DANB.

Use this check-list to determine that you have complied with all of the requirements. Once your application is received, a file will be established and you will be notified if any documents are missing. The Jurisprudence Exam can be taken at any time during this process. Please refer to the Jurisprudence Examination information enclosed with this packet.

_____ Complete and return the Certification and Authorization Form For a Criminal History Background Check (now required by law). Instructions will be provided in a follow-up letter once your application has been received and processed.

_____ Application Fee *(Non-Refundable)*: $35.00
Checks should be made payable to "State of New Jersey" and sent with this application to: **NJ Board of Dentistry, P.O. Box 45005, 124 Halsey Street, 6th Floor, Newark, NJ 07101**

_____ Answer all questions on the application form.

_____ Staple one passport size photograph to the front page of the application. Please sign and print your name along with the date on the back of the photo.

_____ Enter your social security number.

_____ Have your dental assistant school(s) (if applicable) complete the enclosed form verifying that you have completed a CODA approved program in Dental Assisting.

_____ Have your dental assistant school(s) (If applicable) complete the enclosed form verifying that you have completed a Board approved program in expanded functions (If applicable).

_____ Provide proof of completion of the Certification Examination adminstered by DANB.

_____ Provide proof of completion of the New Jersey Expanded Functions Examination adminstered by DANB (if applicable).

_____ If you are applying on the basis of work experience, a Verification of Employment Form must be completed by each employer demonstrating at least two years of work experience during the five year period immediately preceding your application.

_____ Please use additional paper if you cannot fit all of your information in the space provided on this form. Make a notation by each question that more information has been attached. Please mark your attached answers with the same number corresponding to the question that you are answering.

_____ If you have answered 'yes' to any of the child support questions (16-19), please attach an explanation on a separate piece of paper to this application form.

_____ Fill out the Medical Conditions form (MC1.DH) from your packet and send back with your application.

_____ Once the ***entire application*** has been completed, have it signed and sealed by a Notary Public.

Upon approval of your application you will be notified by letter and requested to provide your initial biennial license fee.

Staple a clear, full-face passport-style photograph (2" x 2") of your head and shoulders, taken within the past six months.

For Office Use Only

Application No. _____

Check or Money Order _____

Process Date _____

License No. _____

Application for Dental Assistant License

Date _____

A nonrefundable application fee of $35.00 for licensure in the form of a check or money order made out to the State of New Jersey must be submitted with this application. (Applicants should understand that if the fees are paid with a personal check, and the check is returned by the bank due to insufficient funds, the next step in the licensure process will be delayed until the fees are paid.)

The Board maintains, as part of its responsibilities, a record of your home address, business address and mailing address. You may choose which of these addresses will be considered as your "address of record." If you do not indicate (by putting a check in the appropriate box) which address should be used as your address of record, your mailing address will be considered to be your address of record. A post office box may be used as your address of record, but only if you provide another address which includes a street, city, state and ZIP code.

Information that you provide on this application may be subject to public disclosure as required by the Open Public Records Act (OPRA).

Please print clearly. You must answer all of the questions on this application.

1. Name — Date of birth: _____

Mr. / Mrs. / Ms. _____ (_____)

Last name — First name — Middle initial — Maiden Name

2. Address (Check box for "Address of Record.")

☐ Home: _____

Street or P.O. Box — City — State — Zip code — County

_____ _____

Telephone number (include area code) — E-mail address

☐ Business: _____ _____

Name of company — Telephone number (including area code)

_____

Street — City — State — Zip code — County

☐ Mailing: _____

Street or P.O. Box — City — State — Zip Code — County

3. **Social Security Number** ☐☐☐ ☐☐ ☐☐☐☐

You **must** disclose your Social Security number for the reasons stated below. Failure to do so may result in a denial of licensure or certificate renewal.

Pursuant to N.J.S.A. 2A:17-56.44e of the New Jersey child support enforcement law, and N.J.S.A. 54:50-25 of the New Jersey taxation law and section 1128 E(b)(2)A of the Social Security Act, the Board or licensing agency to which this form is submitted is required to obtain your social security number. If you do not have a Social Security number, the Board must ascertain the reason that you do not have one. The Board is further obligated to provide your Social security number to the Director of Taxation, the Probation Division or other agency responsible for child support enforcement and the H.I.P. Data Bank when reporting adverse actions.

You are also being asked to consent, on a voluntary basis, to the use of your Social Security number for the additional reasons stated below.

You are notified that under the Federal Privacy Act (5 U.S.C. Section 552a (note (b)), the Board or licensing agency to which this form is submitted is requesting the voluntary disclosure of your social security number. If you give your consent for the use of your Social Security number, it may be used: to verify the identity of an applicant, to aid in the collection of financial obligations due and owning the Board or any other state agency, and to aid in the disclosure to state or federal law enforcement and licensing officials and agencies of information obtained in investigations pertaining to licensure and disciplinary proceedings.

I, _____, ☐ Consent ☐ Do Not Consent
Applicant's signature

to the use of my social security number for any purposes set forth above. I understand that my consent is voluntary and that if I do not consent, no adverse action or inference will be taken or drawn.

4. Citizenship / Immigration Status

Federal law limits the issuance or renewal of professional or occupational licenses or certificates to U.S. citizens or qualified aliens. To comply with this federal law, check the appropriate box below which indicates your citizenship/immigration status. If you are not a U.S. citizen, attach a copy of your alien registration card (front and back) or other documentation issued by the Bureau of Citizenship and Immigration Services (B.C.I.S.)

☐ U.S. citizen
☐ Alien lawfully admitted for permanent residence in U.S.
☐ Other immigration status

Questions about your immigration status and whether or not it is a qualified status under federal law should be directed to the B.C.I.S. at: 1-800-375-5283.

EDUCATION

5. List, in chronological order, institutions where you attended dental assisting school, or where you completed a Board approved program in expanded functions.

FOR EACH SCHOOL(S) LISTED BELOW, SCHOOL MUST COMPLETE THE EDUCATION VERIFICATION FORM

Months and Years	Dental Assisting School	City, State, Country
___ / ___ to ___ / ___	_____	_____
___ / ___ to ___ / ___	_____	_____

I completed my program in dental assisting or expanded functions program on the _____day of _____, _____

6. **Other State Board Licenses (complete only if applicable)**
For each state listed, Form SV1.RDA (enclosed with this packet) must be completed by each licensing jurisdiction and sent to the Board office. (Please list all states in which you have or have had a license, including inactive or retired status. Attach a separate sheet of paper if necessary.)

___ State _____ Status _____ ___ State _____ Status _____

___ State _____ Status _____ ___ State _____ Status _____

___ State _____ Status _____ ___ State _____ Status _____

GENERAL QUESTIONS

ALL QUESTIONS *MUST* BE ANSWERED. IF ANY ANSWER IS 'YES', PLEASE SUBMIT A COMPLETE AND ACCURATE EXPLANATION ON A SEPARATE PIECE OF PAPER AND ATTACH IT TO THE APPLICATION.

7. Have you taken any State, Board or Regional Board Dental Assisting Examination(s) and failed? ☐ Yes ☐ No

8. Has your license to practice dental assisting now or ever been subject to disciplinary action in any state? *(If "Yes," please explain on a separate piece of paper.)* ☐ Yes ☐ No

9. Is there any action pending against you by any state licensing board? ☐ Yes ☐ No

10. If you are applying on the basis of work experience, list all employers here. You also may include work experience obtained in the Armed Services, and other positions in health care institutions). Obtain completed Verification of Employment form(s) documenting at least two years of work experience in a dental practice.

_____

_____

_____

_____

11. New Jersey Law and Jurisprudence Exam: Date taken: _____ *(Leave blank if exam has not yet been taken.)*

12. Have you ever been summoned; arrested; taken into custody; indicted; tried; charged with; admitted into pre-trial intervention (PTI); pled guilty to any violation of law, ordinance, felony, misdemeanor or disorderly persons offense; in this or any other state or in a foreign country? (Parking or speeding violations need not be disclosed, but motor vehicle violations such as driving while impaired or intoxicated must be.) ☐ Yes ☐ No

13. Have you ever been convicted of any crime or offense under any circumstances? This includes, but is not limited to a plea of guilty, non vult, nolo contendere, no contest, or finding of guilt by a judge or jury. ☐ Yes ☐ No

    If "Yes," provide a copy of the judgment of conviction and the release from parole or probation. Please provide a complete explanation. (Attach additional sheets of paper to this application.)

14. Have you ever been a defendant in a malpractice suit? ☐ Yes ☐ No

15. Is there now, to your knowledge or belief, any action or investigation pending against you, by a regulatory agency, including but not limited to professional licensing agencies, Medicaid, Medicare, criminal authorities or any other government agency? ☐ Yes ☐ No

CHILD SUPPORT QUESTIONS

In accordance with N.J.S.A. 2A:17-56.44d, an answer of "Yes" to any of the questions numbered 16 - 19 will result in a denial of licensure. Furthermore, any false certification may subject you to a penalty, including, but not limited to, immediate revocation or suspension of licensure.

16. Do you currently have a child-support obligation? If yes, ☐ Yes ☐ No

    a. Are you in arrears in payment of that obligation? ☐ Yes ☐ No

    b. Does the arrears match or exceed the total amount payable for the past six months? ☐ Yes ☐ No

17. Have you failed to provide any court-ordered health insurance coverage during the past six months? ☐ Yes ☐ No

18. Have you failed to respond to a subpoena relating to either a paternity or child-support proceeding? ☐ Yes ☐ No

19. Are you the subject of a child-support-related warrant? ☐ Yes ☐ No

IF YOU HAVE ANSWERED 'YES' TO ANY OF THESE QUESTIONS (7 through 19), PLEASE ATTACH AN EXPLANATION TO THIS APPLICATION.

License No.: _____ Form MC1.DH

For office use only

New Jersey State Board of Dentistry

Please print your name: _____ Date _____

Questions 1 through 9 pertain to medical conditions and use of chemical substances. If you answer "Yes" to question 1, you must answer questions 2 and 3. If you have answered "No" to question 1, continue with questions number 4 through 9. If you answer "Yes" to question 7, answer question 8. Please read the definitions below carefully. Your responses will be treated confidentially, and retained separately. Please be aware that you have a right to elect not to answer those portions of the following questions which inquire as to the illegal use of controlled dangerous substances or activity if you have reasonable cause to believe that answering may expose you to the possibility of criminal prosecution. In that event, you may assert the Fifth Amendment privilege against self-incrimination. Any claim of Fifth Amendment privilege must be made in good faith. If you choose to assert the Fifth Amendment, you must do so in writing to the Board office and confirm that by the answer given to questions number 5 and 9. You must fully respond to all other questions on the application. Your application for licensure will be processed if you claim the Fifth Amendment privilege against self-incrimination. You should be aware, however, that you may later be directed by the Attorney General to answer a question which you have refused to answer on the basis of the Fifth Amendment, provided that the Attorney General first grants you immunity afforded by statutory law (N.J.S.A. 45:1-20).

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

"**Ability to practice dental assisting**" is to be construed to include all of the following:

1. The cognitive capacity to make appropriate clinical findings and exercise reasonable dental assisting judgments and to learn to keep abreast of dental developments; and
2. The ability to communicate those judgments and dental information to patients and to other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
3. The physical capability to perform dental tasks such as dental assisting procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.

"Medical condition" includes physiological, mental or psychological conditions or disorders such as, but not limited to, orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction and alcoholism.

"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.

"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 may have an ongoing impact on one's functioning as a licensee, or within the past two (2) years.

"Illegal use of controlled dangerous substances" means the use of controlled dangerous substances obtained illegally (e.g. heroin or cocaine) as well as the use of controlled dangerous substances which are not obtained pursuant to a valid prescription or not taken in accordance with the directions of a licensed health care practitioner.

1. Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety? Yes ☐ No ☐

2. If you answered "YES" to question 1, are the limitations or impairments caused by your medical condition reduced or ameliorated because you receive ongoing treatment (with or without medications) or participate in a monitoring program**? Yes ☐ No ☐

3. If you answered "YES" to question 1, are the limitations or impairments caused by your medical condition reduced or ameliorated because of the field of practice, the setting or manner in which you have chosen to practice? Yes ☐ No ☐

4. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism or voyeurism? Yes ☐ No ☐
(See Question 5 for the Fifth Amendment option before responding.)

5. If you have chosen not to answer question 4 and instead have submitted a written Fifth Amendment assertion to the board office, check the "YES" box here. Yes ☐ No ☐

6. Does your use of chemical substance(s) in any way impair or limit your ability to practice your profession with reasonable skill and safety? Yes ☐ No ☐

If this question does not apply, check both the "No" box and the "Not Applicable" box. Not applicable ☐

7. Are you currently engaged in the illegal use of controlled dangerous substances? (Recall that "currently" is defined as "within the last two years.") Yes ☐ No ☐
See Question 9 for the Fifth Amendment option before responding.

8. If you answered "YES" to Question 7, are you currently participating in a supervised rehabilitation program or professional assistance program which monitors you in order to assure that you are not engaging in the illegal use of controlled dangerous substances? Yes ☐ No ☐

9. If you have chosen not to answer question 7 above and instead have submitted a written Fifth Amendment assertion to the Board office, check the "YES" box here. Yes ☐ No ☐

** If you receive such ongoing treatment or participate in such a monitoring program, the Board will make an individualized 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 not eligible for licensure.

"I certify that the information entered on this form is true and complete to the best of my knowledge, and further acknowledge that if the above information is willfully false, I am subject to punishment and/or disciplinary sanction including license suspension/revocation or the imposition of civil penalties as may be provided by law."

_____ _____
Signature of Licensee Date

_____
Print Name

State of New Jersey, County of _____ , _____

Name of Applicant

of _____

Address of applicant

Waiver

I hereby authorize all hospitals or institutions or organizations, my references, employers (past and present), business and professional associations (past and present), and all governmental agencies and instrumentalities (local, state, Federal or foreign) to release to the New Jersey State Board of Dentistry any information, files or records requested by the Board in connection with the processing of this application. I further authorize the New Jersey State Board of to release to the organizations, individuals and groups listed above information which is material to my application.

I have carefully read the questions in the foregoing application and have answered them completely without reservation, and I declare under penalty of perjury that my answers and all statements made by me therein are true and correct. Should I furnish any false information in this application, I hereby acknowledge that such act shall constitute cause for the denial, suspension or revocation of my license to practice dentistry in the State of New Jersey.

I realize that the foregoing information is necessary for an evaluation of my application, of which this is a part, and I fully recognize that full disclosure is essential to such procedures.

I have read the above and fully understand the contents.

_____

Signature of Applicant

Sworn and subscribed to before me this

_____ day of _____, 20_____

_____

Notary Public

DO NOT WRITE IN THIS SPACE

Date Received _____

Application Number _____

License Number _____

DANB
Certification Date _____

Expanded Functions
Certification Date _____

_____

_____

New Jersey Board of Dentistry

P.O. Box 45005 . 124 Halsey Street . 6th Floor . Newark, NJ 07101 . 973-504-6405

Verification of Employment/Education - DENTAL ASSISTING

A separate form must be used for each employer or educational institution.

(This form may be reproduced.)

NAME OF APPLICANT: _____

First Middle Last

NOTE: This section should be completed if the applicant is applying on the basis of work experience.

The above named applicant is/was employed by me from _____ until

Month/Day/Year

_____

Month/Day/Year

The applicant was employed on a _____ full time _____ part time b If part time list avg. number of hours per week:_____

NOTE: This section should be completed if the applicant is applying on the basis of education. Verification Form should contain the raised seal of educational institution.

The above referenced individual successfully completed the following academic programs:

☐ A CODA approved program in Dental Assisting on _____

Date

☐ A Board-approved program in "Expanded Functions" on _____

Date

Certification

I hereby certify that to the best of my knowledge and belief, the foregoing is a true statement of the record of the individual on this form.

Name of Practice or Educational Inst. _____

Name of Person Completing Form _____

License number (if applicable) _____

Title _____

(School Seal)

Signature _____

Date _____

New Jersey State Board of Dentistry
Jurisprudence Examination

Please use the small white booklet, the New Jersey State Board of Dentistry book of Statutes & Regulations, to prepare for the Jurisprudence examination.

If you are a New Jersey resident:

All New Jersey residents are required to take the Jurisprudence Examination at the Board of Dentistry administrative offices in Newark, New Jersey. If you are a New Jersey resident, or an out of state resident who will be in the area, please use the attached form to schedule a time to take the exam.

If you live outside of New Jersey:

You may have the Jurisprudence exam proctored if you live out of state. Proctored tests can be handled in the following ways:

a. Individuals requesting the Jurisprudence Exam may have their exam proctored by a licensed dentist.

b. Students requesting the Jurisprudence Exam may have their exam proctored by a faculty member from their school.

Anyone requesting to proctor the Jurisprudence Examination may write a letter to the Board. The letter should include the following information:

Number of exams requested.

1. Date of examination.
2. Type of examination: Dental, RDH or RDA.
3. Name, address, institution and title of proctor.
4. Contact name and phone number.
5. Address where exam(s) should be mailed.
6.

This letter may either be faxed to: 973-273-8075, or sent by mail to:
NJ Board of Dentistry, P.O. Box 45005, 124 Halsey Street, 6th Floor, Newark NJ 07101

New Jersey Office of the Attorney General
Division of Consumer Affairs
New Jersey State Board of Dentistry
124 Halsey Street, 6th Floor, P.O. Box 45005
Newark, New Jersey 07101
(973) 504-6405

Jurisprudence Examination Registration Form

If you are a New Jersey resident (or an out-of-state resident wishing to take the Jurisprudence Exam at the Board's administrative offices), please check off which date and time you would like to take the test. On each of the dates listed below, the test is given at 10:00 a.m. and 1:00 p.m. Please send this form via fax or mail it to the address below. You will have one hour to complete this closed book examination. If the session is full, you will be contacted to reschedule. Please include your daytime telephone number.

The following is a schedule of the Exam dates for 2013

January 2nd	☐ 10:00 a.m.	☐ 1:00 p.m.
January 16th	☐ 10:00 a.m.	☐ 1:00 p.m.
February 6th	☐ 10:00 a.m.	☐ 1:00 p.m.
February 20th	☐ 10:00 a.m.	☐ 1:00 p.m.
March 6th	☐ 10:00 a.m.	☐ 1:00 p.m.
March 20th	☐ 10:00 a.m.	☐ 1:00 p.m.
April 3rd	☐ 10:00 a.m.	☐ 1:00 p.m.
April 17th	☐ 10:00 a.m.	☐ 1:00 p.m.
May 1st	☐ 10:00 a.m.	☐ 1:00 p.m.
May 15th	☐ 10:00 a.m.	☐ 1:00 p.m.
June 5th	☐ 10:00 a.m.	☐ 1:00 p.m.
June 19th	☐ 10:00 a.m.	☐ 1:00 p.m.
July 10th	☐ 10:00 a.m.	☐ 1:00 p.m.
July 24th	☐ 10:00 a.m.	☐ 1:00 p.m.
August 14th	☐ 10:00 a.m.	☐ 1:00 p.m.
September 4th	☐ 10:00 a.m.	☐ 1:00 p.m.
September 18th	☐ 10:00 a.m.	☐ 1:00 p.m.
October 2nd	☐ 10:00 a.m.	☐ 1:00 p.m.
October 16th	☐ 10:00 a.m.	☐ 1:00 p.m.
November 6th	☐ 10:00 a.m.	☐ 1:00 p.m.
November 20th	☐ 10:00 a.m.	☐ 1:00 p.m.
December 4th	☐ 10:00 a.m.	☐ 1:00 p.m.
December 18th	☐ 10:00 a.m.	☐ 1:00 p.m.

Candidate's name (please print) _____

Daytime telephone number (include area code) _____

Please put a check in one box: ☐ Dental ☐ R.D.H. ☐ R.D.A.

Return this form to:

New Jersey State Board of Dentistry
124 Halsey Street, 6th Floor
P.O. Box 45005
Newark, NJ 07101

Fax number: (973) 273-8075

Official Use Only
☐ Dual License
License Type 1

Applicant's Number

License Type 2

Applicant's Number

New Jersey Office of the Attorney General
Division of Consumer Affairs
New Jersey State Board of Dentistry
P.O. Box 45005
Newark, New Jersey 07101
(973) 504-6405

Official Use Only

☐ Resubmit

Board or Committee

Certification and Authorization Form For a Criminal History Background Check

Directions: Answer all of the questions on this form.

1. Name ☐ Mr. ☐ Mrs. ☐ Ms. _____ (_____)
   Last First Middle Maiden Name
2. Address _____
   Street or P.O. Box City State ZIP code
3. Date of birth __ __ /__ __ /__ __ Sex: ☐ Male ☐ Female
   Month Day Year
4. Social Security number _____/_____ / _____
5. Have you completed the fingerprinting process for any **Board or Committee of the New Jersey Division of Consumer Affairs** since November 2003? ☐ Yes ☐ No
   If "No," you will receive a separate mailing from the Board or Committee regarding the criminal history record background check process. No payment is necessary as of now.
   If "Yes," please provide the following information and follow the instructions outlined below:

   _____ _____
   Board or committee requiring the fingerprinting Month and year you were fingerprinted

   If you were fingerprinted after November 2003 as part of the criminal history background process for licensure or certification by any other **Board or Committee of the New Jersey Division of Consumer Affairs** (a background check conducted for the Department of Education, another state agency or another state does not apply) you will not be required to be fingerprinted a second time. However, the Division must perform a criminal history background check each time you apply for licensure or certification. **The fee for this service is $22.55.** Payment should be made in the form of a check or money order payable to the State of New Jersey and should accompany your application packet.
6. Have you ever been arrested and/or convicted of a crime or offense? (Minor traffic offenses such as a parking or speeding violations need not be listed.) ☐ Yes ☐ No

   Every such conviction on record must be disclosed. A true copy of every police report, judgment of conviction, sentencing order and termination of probation order, if applicable, **must** be submitted with this form. Any documents (including employer or supervisor letters of reference, if applicable) which present clear and convincing evidence of rehabilitation **must** be submitted with this form. **Failure to follow these instructions may result in the denial of an initial application.**

   Note: Copies of judgments, sentencing and termination of probation orders may be obtained from the clerk of the county where those orders, disposing of the conviction, were issued and filed.

   Your continuing responsibility to disclose convictions of crimes or offenses: You **must** notify the Board or Committee within five (5) business days if you are convicted of any crimes or offenses after this form has been completed.

Continuation on the reverse side ➡

Certification

I, _____, in making this application to the Board or Committee for certification or licensure, certify that I am the applicant and that all of the information provided in connection with this application is true to the best of my knowledge and belief. I understand that any omissions, inaccuracies or failure to make full disclosures may be deemed sufficient to deny certification or licensure or to withhold renewal of or suspend or revoke a certificate or license issued by the Board or Committee.

I voluntarily consent to a thorough investigation of my present and past employment and other activities for the purpose of verifying my qualifications for certification or licensure. I further authorize all institutions, employers, agencies and all governmental agencies and instrumentalities (local, state, federal or foreign) to release any information, files or records requested by the Board or Committee.

I certify that the foregoing statements made by me are true. I am aware that if any of the foregoing statements made by me are willfully false, I am subject to punishment.

_____ _____

Signature of applicant Date