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

APPLICATION INSTRUCTIONS FOR LICENSURE AS A DENTIST BY CRITERIA (RECIPROCITY)

I. THE APPLICATION PROCESS

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

There are different avenues for licensure as a dentist in Tennessee. Below are definitions of each avenue. Please carefully read and determine the process that is applicable to you.

Examination - This method is applicable to any dentist who has successfully completed one of the following examinations: Southern Regional Testing Agency (SRTA), Northeast Regional Board (NERB), Central Regional Dental Testing Service (CRDTS) or Western Regional Examining Board (WREB). Please download the application at http://tn.gov/health/topic/Dentistry-board. Please refer to Rule 0460-02-.01(1) & (2) and the Board's examination policies for more information. The ADEX examination is accepted. Council of Interstate Testing Agency (CITA) examination is accepted if it was the ADEX examination that was administered.

Criteria (Reciprocity) - This method allows a dentist who is licensed in another state and has actively practiced or taught for at least five (5) years to be considered for licensure without taking a regional examination. Applicants who have practiced or taught for at least two (2) years BUT less than five (5) years must request the examination scores and any additional information requested by the Board be submitted directly from the examination agency. Any accepted regional examination must never have been failed without subsequently retaking and passing to qualify by criteria approval. Please refer to Rule 0460-02-.01(1) & (3) for more information.

Limited License – This process is applicable to a dentist who graduated from a non-ADA accredited program with a degree substantially equivalent to either a D.D.S. or D.M.D. degree and has successfully completed a graduate training program in a recognized specialty branch of dentistry from an advanced specialty program accredited by the ADA. This type of license limits the practice location to ADA accredited institutions, dental education programs or in federally-designated health professional shortage areas. Proof of employment to practice in any of these locations is required upon initial application and subsequent renewal of this license. Please download the application at http://tn.gov/health/topic/Dentistry-board. Please refer to Rule 0460-02-.03(1) & (2) for more information.

Limited Educational License - This process is applicable to a dentist licensed in another state and who will be teaching in a dental educational institute. This type of license limits the practice location to programs offered by the educational institution. Upon termination of faculty appointment, the license is void. Please download the application at http://tn.gov/health/topic/Dentistry-board. Please refer to Rule 0460-02-.03 (1) & (3) for more information.

Dual Degree Licensure - This process is applicable to a dentist who is licensed in Tennessee as a Medical Doctor and who possesses an active dental license which is in good standing in at least one (1) other state. You may use the *Application for Licensure as a Dentist* as the Dual Degree Licensure application. **However**, the supporting documentation is different and you must apply for your specialty certification at the same time you apply for your dual degree license. Please refer to Rule 0460-02-.02 for more information.

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 Five Hundred Sixty Dollars ($560) made payable to the "Board of Dentistry" to the front of the Application.	___
4.	Request an official transcript from the institution from which you completed your ADA accredited dental school. The transcript must be mailed directly to the Board of Dentistry.	___
5.	Submit two (2) **Original** letters of recommendation from licensed dental professionals who can attest to your good moral character. These letters must identify the individual(s) as licensed dental professionals, be submitted on letterhead, and bear the original signature of the author.	___
6.	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).	___
7.	Submit a copy of all current and valid licenses to practice dentistry which you currently hold. You must have an active license in at least one other state.	___

8. Request to have your National Board scores forwarded directly to the Board of Dentistry if you did not request Tennessee receive the scores within the last year. 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. 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. ___

10. Attach proof of U.S. or Canadian citizenship or evidence of being legally entitled to live in the U.S. (e.g. copy of birth certificate, voter's registration card, U.S. passport, naturalization papers, or current visa status.) ___

11. 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. ___

12. Proof of intent to actively practice or teach in Tennessee by submitting proof of employment as a dentist, or by submitting proof of starting a private dental practice in Tennessee. ___

13. If you have ever taken any accepted regional examination, proof of passage of any of these examinations must be received directly from the testing agency. Any accepted regional examination must never have been failed without subsequently retaking and passing to qualify by criteria approval. ___

14. Proof of practice in private dental practice or teaching in an ADA accredited institution in another state or states for at least five (5) years **or** proof of successful completion of an examination administered by another state which is substantially equivalent to the examination required for initial licensure in Tennessee (as determined by the Board) and proof of practice in a private dental practice or teaching in an ADA accredited institution for at least two (2) years ___

15. Applicants who have practiced or taught for at least two (2) years BUT less than five (5) years must request the examination scores and any additional information requested by the Board be submitted directly from the examination agency. ___

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 the Declaration of Citizenship form and submit the documents required. The Declaration is available 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 license (see Rules 0460-02-.06 and/or 0460-02-.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

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

FOR OFFICIAL USE ONLY

FEES IF APPLYING BY CRITERIA (RECIPROCITY)

1201-001	$ 550
1201-006	$ 10
	$ 560

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APPLICATION FOR LICENSURE AS A DENTIST BY CRITERIA (RECIPROCITY)

Please complete each question and return the form, supporting documents, and the Five Hundred Sixty Dollar ($560) 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 attached 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 ADA accredited 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 healthcare 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 and proof of practice/employment must be submitted.

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: _____

8.	Do you have any pending disciplinary charges or action or any current investigation by any disciplinary authority?		

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.***

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 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 dentist 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 dentist.

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 _____