Maryland State Board of Dental Examiners
Spring Grove Hospital Center • Benjamin Rush Building
55 Wade Avenue/Tulip Drive
Catonsville, Maryland 21228
(410) 402-8511

APPLICATION TO PARTICIPATE IN AN ADVANCED CLINICAL TRAINING PROGRAM FOR CONTINUING EDUCATION

TO BE COMPLETED ONLY BY THOSE DENTISTS WHO DO NOT HOLD A LICENSE TO PRACTICE DENTISTRY IN MARYLAND

Notice

This application is for dentists licensed in a state other than Maryland who wish to participate in an advanced clinical training program for continuing education. If you hold an active general license to practice dentistry in Maryland, you should not compete this application, and approval from the Maryland State Board of Dental Examiners ("the Board") is not required for you to attend an advanced clinical training program for continuing education. Dentists licensed in a state other than Maryland must receive written approval from the Board before they may participate in an advanced clinical training program for continuing education. To ensure sufficient processing time, the completed application and $25 fee must be received in the offices of the Board at least 45 days before the commencement of the program. The information collected on this application form is collected for the purposes of the Board's functions under the Annotated Code of MD, Health Occupations Article, Title 4, and the Code of Maryland Regulations (COMAR) Title 10, Subtitle 44. Failure to provide the information may result in denial of your application. You have a right to inspect, amend, and request correction of this information. The Board may permit inspection of this information or make it available to others only as permitted by federal and State law.

SECTION I – GENERAL INFORMATION

Name (Last, First, Middle Initial):	
Address of Record: (Street Address)	
City, State, Zip:	

A. Social Security Number: ☐☐☐-☐☐-☐☐☐☐
(There is a statutory requirement that you disclose your social security number. It will be used for identification purposes only.)

B. Date of Birth: ☐☐-☐☐-☐☐☐☐

C. Cell Phone Number: ☐☐☐-☐☐☐-☐☐☐☐

D. Home Phone Number: ☐☐☐-☐☐☐-☐☐☐☐

E. Work Phone Number: ☐☐☐-☐☐☐-☐☐☐☐

F. E-Mail Address: ☐

G. Gender Identification: ☐ Female ☐ Male

H. Race/Ethnic Identification – Please check <u>all</u> that apply

Are you of Hispanic or Latino origin? Yes ☐ No ☐
(A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.)

Select one or more of the following racial categories:

1. ☐ American Indian or Alaska Native (A person having origins in any of the original peoples of North or South America, including Central America, and who maintains tribal affiliations or community attachment.)
2. ☐ Asian (A person having origin in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.)
3. ☐ Black or African American (A person having origins in any of the black racial groups of Africa.)
4. ☐ Native Hawaiian or other Pacific Islander (A person having origins in the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.)
5. ☐ White (A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.)

I. Licensure in other states:

List other states or jurisdictions in which you hold or have held a dental license. Include license number(s).

State	License Number	Expiration Date

Note: You must enclose with this application certified letters with the state seal affixed from each state in which you hold or held a dental license verifying that the license is or was in good standing

<u>SECTION II – ADVANCED CLINICAL TRAINING PROGRAM</u>

A. Title of advanced clinical training program: _____

B. Dates of program: _____

C. Number of continuing education hours: _____

<u>SECTION III - EDUCATION</u>

A. School of graduation (Name, City, State, Country): _____

_____

B. Date of graduation: _____ **Degree earned: _____**

SECTION IV - CHARACTER AND FITNESS

If you answer "YES" to any question(s) in Section IV – Character and Fitness, attach a separate page with a complete explanation of each occasion. Each attachment must have your name in print, signature, and date.

YES	NO	
❒	❒	a. Has any licensing or disciplinary board of any jurisdiction, including Maryland, or any federal entity denied your application for licensure, reinstatement, or renewal, or taken any action against your license, including but not limited to reprimand, suspension, revocation, a fine, or non-judicial punishment? If you are under a Board Order or were ever under a Board Order in a state other than Maryland you must enclose a certified legible copy of the entire Order with this application.
❒	❒	b. Have any investigations or charges been brought against you or are any currently pending in any jurisdiction, including Maryland, by any licensing or disciplinary board or any federal or state entity?
❒	❒	c. Has your application for a dentist license in any jurisdiction been withdrawn for any reason?
❒	❒	d. Has an investigation or charge been brought against you by a hospital, related institution, or alternative health care system?
❒	❒	e. Have you had any denial of application for privileges, been denied for failure to renew your privileges, or limitation, restriction, suspension, revocation or loss in privileges in a hospital, related health care facility, or alternative health care system?
❒	❒	f. Have you pled guilty, nolo contendere, had a conviction or receipt of probation before judgment or other diversionary disposition of any criminal act, excluding minor traffic violations?
❒	❒	g. Have you pled guilty, nolo contendere, had a conviction, or receipt of probation before judgment or other diversionary disposition for an alcohol or controlled dangerous substance offense, including but not limited to driving while under the influence of alcohol or controlled dangerous substances?
❒	❒	h. Do you have criminal charges pending against you in any court of law, excluding minor traffic violations?
❒	❒	i. Do you have a physical condition that impairs your ability to practice dentistry?
❒	❒	j. Do you have a mental health condition that impairs your ability to practice dentistry?
❒	❒	k. Have the use of drugs and/or alcohol resulted in an impairment of your ability to practice dentistry?
❒	❒	l. Have you illegally used drugs?
❒	❒	m. Have you surrendered or allowed your license to lapse while under investigation by any licensing or disciplinary board of any jurisdiction, including Maryland, or any federal or state entity?
❒	❒	n. Have you been named as a defendant in a filing or settlement of a malpractice action?
❒	❒	o. Has your employment been affected or have you voluntarily resigned from any employment, in any setting, or have you been terminated or suspended, from any hospital, related health care or other institution, or any federal entity for any disciplinary reasons or while under investigation for disciplinary reasons?

The Well Being Committee assists dentists and their families who are experiencing personal problems. The Committee has helped many dentists over the years with problems such as stress, drug dependence, alcoholism, depression, medical problems, infectious diseases, neurological disorders and other illnesses that cause impairment. For more information, go to www.dentistwellbeing.com.

SECTION V – MALPRACTICE INSURANCE

A. Name of malpractice insurer: _____

B. Name, address, and telephone number of malpractice insurance agent, or if no agent, the address and telephone number of the malpractice insurer:

_____

_____

C. Policy number: _____

D. Amount of coverage: _____

E. Expiration date of policy: _____

Release and Certification:

I hereby affirm that I have read and followed the above instructions. I hereby certify that all information in this application is accurate and correct.

I agree that the Board may request any information necessary to process my application from any person or agency, including but not limited to postgraduate program directors, individual dentists, government agencies, the National Practitioner Data Bank, the Healthcare Integrity and Protection Data Bank, hospitals and other licensing bodies, and I agree that any person or agency may release to the Board the information requested. I also agree to sign any subsequent release for information that may be requested by the Board.

I agree that I will fully cooperate with any request for information or with any investigation related to my dental practice as a licensed dentist including the subpoena of documents or records.

During the period in which my application is being processed, I shall inform the Board within forty-eight hours of any change to any answer I originally gave in this application, or change of address.

I agree that any approval I may receive from the Board to participate in a specific advanced clinical training program for continuing education shall be approval to participate in, and practice dentistry within that specific program only. Application must be made for, and approval obtained from the Board to participate in each advanced clinical training program for continuing education.

_____ _____

Applicant Signature **Date**

NOTARY SECTION

State of _____, County of _____, Then personally appeared the above named _____, and signed and sworn to the truth of the foregoing statements in my presence.

Notary Public: _____ My Commission Expires: _____

SEAL

Revised 04/29/21