PLEASE SUBMIT $150.00 APPLICATION FEE

MARYLAND STATE BOARD OF DENTAL EXAMINERS
Spring Grove Hospital Center • The Benjamin Rush Building
55 Wade Avenue • Tulip Drive
Catonsville, Maryland 21228
(410) 402-8511

APPLICATION FOR BOARD IDENTIFICATION AS A SPECIALIST

Pursuant to the Code of Maryland Regulations, 10.44.14 I hereby make the following application:

1. Name: _____
   Last First Middle

2. Date of Birth: _____

3. Mailing Address: _____
   No & Street City State Zip Code

4. Telephone Number: (____) _____

5. Dental Degree from: _____ Year of Graduation: _____

6. I am licensed to practice dentistry in the following states:

   _____ License # _____

   _____ License # _____

   _____ License # _____

7. Check the area of specialty that is applicable to you. The Board recognizes the following areas of dentistry as specialties:

   - ☐ Dental Anesthesiology
   - ☐ Dental Public Health
   - ☐ Endodontics
   - ☐ Oral and Maxillofacial Pathology
   - ☐ Oral and Maxillofacial Radiology
   - ☐ Oral Medicine
   - ☐ Oral and Maxillofacial Surgery
   - ☐ Orthodontics and Dentofacial Orthopedics
   - ☐ Pediatric Dentistry
   - ☐ Periodontics
   - ☐ Prosthodontics
   - ☐ Orofacial Pain

8. Specialty Training Received: _____ _____
   Dental School Name Dates of Attendance

   Year certificate received: _____.

I hereby enclose **certified** proof of completion of a Board approved specialty training program (such as a copy of certificate or a letter from the school). I understand that **an original school certification must be affixed to transcript or diploma documents. Letters from educational institutions on original letterhead, bearing an original signature do not require a raised, embossed school seal.**

9. **Answer only** if you have not completed a specialty training program:

a. Have you reasonably represented to the public that you were a specialist prior to July 1, 1979? ____If so, how many years?

b. I hereby certify that I have been specializing in the field of _____ prior to July 1, 1979, and reasonable represented to the public that I was a specialist and limited my practice to the above identified specialty field. The dates during which I have limited my practice to that specialty are _____.

c. On a separate sheet of paper identify the education and experience on which your claim to be a specialist is based.

TO BE COMPLETED BY ALL APPLICANTS

Signed: _____
Signature of Applicant

A F F I D A V I T

State of _____

County of_____

I hereby certify that on this _____ day of _____, 20___, before me the subscriber, a notary public, in and for the county aforesaid, personally appeared _____ and made oath in due form of law that the above facts are true to the best of the applicant's knowledge. As witness, my hand and notarial seal.

_____
Notary Public

S E A L

My Commission expires on: _____

Revised 12-03-20

INSTRUCTIONS FOR APPLICATION
FOR BOARD IDENTIFICATION AS A SPECIALIST

1. In accordance with the Code of Maryland-Regulations, 10.44.14, these instructions have been developed to facilitate the completion of the Application for Board Identification as a Specialist.

2. An applicant may apply for the following areas of dentistry as specialties:

Dental Anesthesiology	Oral and Maxillofacial Surgery
Dental Public Health	Orthodontics and Dentofacial Orthopedics
Endodontics	Pediatric Dentistry
Oral and Maxillofacial Pathology	Periodontics
Oral and Maxillofacial Radiology	Prosthodontics
Oral Medicine	Orofacial Pain

Any area of specialty approved by the Commission on Dental Accreditation or its successor organization.

3. Only a licensed dentist, who has successfully completed a Board-approved specialty training program.

4. Applicants must provide certified proof of such program or a written statement, under oath, that sets forth the basis for the dentist's claim that, before July 1, 1979 (see Code of Maryland-Regulations 10.44.14.05 (C) 1 and 2).

5. The applicable non-refundable fee is $150. Make all remittances payable to the State Board of Dental Examiners. **DO NOT SEND CASH.**

Incomplete applications will be returned and will be subject to a $50.00 application reprocessing fee.

6. The completed application is to be forwarded to:

Maryland State Board of Dental Examiners
Spring Grove Hospital Center
The Benjamin Rush Building
55 Wade Avenue/Tulip Drive
Catonsville, Maryland 21228

7. Any questions concerning the completion of the application or the process may be directed to Ms. Deborah A. Welch, Licensing Coordinator at (410) 402-8511.

Revised 12-03-20