



**FLORIDA STATE BOARD OF DENTISTRY
RESIDENCY/INTERN APPLICATION**

Chapter 466.025(1), Florida Statutes
Rule 64B5-7.001 and 7.003, Florida Administrative Code

This application is pursuant to the above statute and rule. Any question not applicable must be indicated accordingly (N/A). Institutions may copy this application. The Florida State Board of Dentistry will not consider incomplete applications or faxed copies that are not legible. Please TYPE all responses.

***PLEASE ATTACH A COPY OF A CURRENT BASIC LIFE SUPPORT LEVEL CPR CERTIFICATION.**

PART I – PROFILE DATA

¹ List your full, legal NAME as it should appear on RESIDENCY/INTERN Permit (no nicknames or shortened versions):	
FIRST:	MIDDLE: LAST:
² Date of Birth:	
³ Telephone: Daytime () Evening ()	
⁴ Dental/Medical School Attended:	
⁵ Date Graduated (Attach copy of diploma or final transcript-Required):	⁶ Type of Degree: <input type="checkbox"/> D.D.S. <input type="checkbox"/> D.M.D.
⁷ Name of institution seeking approval:	⁸ Name of Resident Director or Chief:
⁹ Mailing address of institution seeking approval:	
¹⁰ Telephone: ()	¹¹ Contact Person/Title:
¹² Is this an initial permit?	YES NO
¹³ If no, when did you enter the residency program?	Permit #
¹⁴ Name/Type of residency program:	
¹⁵ Name(s) and license number(s) of Florida licensed dentist(s) providing supervision:	
Name:	License Number:
Name:	License Number:
Name:	License Number:

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www.doh.state.fl.us/mqa/dentistry

Please attach a copy of applicant's diploma and/or final official transcripts from graduating dental school.
Please also attach proof of current CPR training at the basic life support level – online courses are not applicable.

On behalf of this institution, I certify that the information provided on this application is true and accurate to the best of our knowledge.

Resident Director or Chief

Date

I declare under penalty of perjury that the answers provided on this application are true and accurate. I agree that submission of false information by any party completing this application shall constitute cause for the denial, suspension, or revocation of this permit or dental license to practice in the state of Florida.

Pursuant to rule 64B5-7.003, F.A.C., I acknowledge that experience obtained pursuant to a permit issued under the authority of this rule and section 466.025, F.S., is not acceptable for the purpose of fulfilling the supplemental education program set forth in section 466.006(3)(c), F.S.

Signature of applicant

Date

PART II - PERSONAL AND LICENSURE HISTORY

ALL OF THE FOLLOWING QUESTIONS MUST BE ANSWERED.

If you answer "YES" to ANY of the following questions, explain in full by addendum to the application. You must make a statement that includes, but is not limited to, the date(s), location(s), specific circumstances, practitioners and/or treatment involved, etc., pertaining to the "YES" answer. If you have been under treatment for a mental or physical illness or condition that affects your ability to practice dentistry, you must request that each practitioner, hospital, and program involved in your treatment submit a full, detailed report of such to the board office. Any "YES" answer must be substantiated by either official documents sent directly to the board office from the respective state licensing board or official copies of court records. A "YES" answer is NOT an automatic cause for denial of licensure.

In addition to your submission of necessary documentation for any "YES" answer to these questions, your answers may result in your being referred to the Physicians Recovery Network (PRN) for evaluation. The PRN is a consultant to the State of Florida contracted to evaluate practitioners to ensure their ability to practice with reasonable skill and safety to the public. If you have any questions, the board staff may be able to assist you in determining whether the evaluation will be necessary in your case. Additionally, a personal appearance before the board may be requested in some cases, regardless of whether the PRN is involved.

NOTE: Obtaining or attempting to obtain a license by bribery, fraud, or knowing misrepresentation is a violation of the Dental Practice Act and may result in the denial of licensure, suspension or revocation of license, and/or other penalty under section 466.028, Florida Statutes, or Rule Chapter 64B5-13, F.A.C.

<p>¹ Have you ever been convicted of, or entered a plea of guilty, nolo contendere, or no contest to a crime in any jurisdiction other than a minor traffic offense? You must include all misdemeanors and felonies, even if adjudication was withheld by the court so that you would not have a record or conviction. Driving under the influence or driving while impaired is not a minor traffic offense for purposes of this question. If yes, please list date, jurisdiction (state and county), offense, disposition, and all other relevant information on reverse side or an attached sheet</p>	<p>YES NO</p>
<p>² Have you been enrolled in, required to enter into, or participated in any drug and/or alcohol recovery program or impaired practitioner program for treatment of drug or alcohol abuse that occurred within the past five years?</p>	<p>YES NO</p>
<p>³ Have you been treated for or had a recurrence of a diagnosed mental disorder that has impaired your ability to practice dentistry/dental hygiene within the past five years?</p>	<p>YES NO</p>
<p>⁴ Were you admitted or directed into a program for the treatment of a diagnosed substance-related (alcohol/drug) disorder or, if you were previously in such a program, did you suffer a relapse within the last five years?</p>	<p>YES NO</p>

⁵ Have you been treated for or had a recurrence of a diagnosed substance-related (alcohol/drug) disorder that has impaired your ability to practice dentistry within the last five years?	YES	NO
⁶ Pursuant to Section 456.0635(2), Florida Statutes, the following questions are being asked. If you answer yes to any of the following questions, explain on a separate sheet providing accurate details and submit copies of supporting documentation.		
^{7a} . Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under Chapter 409, Chapter 817, or Chapter 893, Florida Statutes; or 21 U.S.C. ss. 801-970 or 42 U.S.C. ss. 1395-1396? (If no, do not answer 7b.)	YES	NO
^{7b} . Has it been more than 15 years prior to the date of this application since the sentence and completion of any subsequent period of probation for such conviction?	YES	NO
^{7c} . Have you ever been terminated for cause from the Florida Medicaid Program pursuant to Section 409.913, Florida Statutes? (If no, do not answer 7d.)	YES	NO
^{7d} . If you have been terminated but reinstated, have you been in good standing with the Florida Medicaid Program for the most recent five years?	YES	NO
^{7e} . Have you ever been terminated for cause, pursuant to the appeals procedures established by the state or federal government, from any other state Medicaid program or the federal Medicare program? (If no, do not answer 7f and 7g)	YES	NO
^{7f} . Have you been in good standing with a state Medicaid program or the federal Medicare program for the most recent five years?	YES	NO
^{7g} . Did the termination occur at least 20 years prior to the date of this application?	YES	NO
⁸ Have you ever been denied the right to take a Dental or any other licensure examination in any state?	YES	NO
⁹ Have you ever been refused a license to practice Dentistry or any other license or the renewal thereof in any state?	YES	NO
¹⁰ Have you ever had a license revoked or a certificate of registration to practice Dentistry or any other licensed profession revoked, suspended or otherwise acted against (including probation, fine or reprimand) in a disciplinary proceeding in any state?	YES	NO
¹¹ Are you now or have you ever been a defendant in civil litigation in which the basis of the complaint against you was in alleged negligence, malpractice or lack of professional competence?	YES	NO
¹² Is there currently pending against you in any jurisdiction a complaint against your professional conduct or competence as a Dentist or other licensed professional? <ul style="list-style-type: none"> If Questions 8-12 above are answered "YES", you must provide complete details as to state(s), license number(s), dates, and relevant circumstances on reverse side or on attached sheets. 	YES	NO

PART III - APPLICANT RELEASE AND AFFIDAVIT

THE FOLLOWING STATEMENT MUST BE COMPLETED:

APPLICANT RELEASE AND AFFIDAVIT:

I, _____, state that I am the person referred to in the foregoing Residency/Intern permit application and supporting documentation, that said application and any supporting documentation are true and accurate.

I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past and present), business and professional associates (past and present), and all governmental agencies and instrumentalities (local, state, federal and foreign) to release to the Florida Department of Health any information, files, or records requested by the agency in connection with the processing of this application. I further authorize the Florida Department of Health to release to any organization, individual or group listed above any information which is material to my application.

I understand that it is my responsibility to supplement my application as needed to reflect any material changes in any circumstance or condition stated in the application which might affect the decision of the department and which takes place between the initial filing of the application and the final granting or denial of residency/intern permit.

I have carefully read the instructions and questions in the foregoing application and have answered them completely, without reservations of any kind. Should I furnish any false information in this application, or in any supporting documentation, I acknowledge that such an act constitutes cause for denial, disciplinary action, suspension or revocation of my residency/intern permit to practice dentistry under Chapter 466, Florida Statutes, Chapter 456, Florida Statutes, and Chapter 64B5, Florida Administrative Code, in the State of Florida.

I hereby affirm that I have received, read and understood Chapter 466, Florida Statutes, Chapter 456, Florida Statutes, and Chapter 64B5, Florida Administrative Code, and acknowledge that I must abide by them.

Signature of applicant _____

Date _____