



# ARKANSAS STATE BOARD OF DENTAL EXAMINERS

101 East Capitol Avenue, Suite 111  
Little Rock, Arkansas 72201  
Phone: 501-682-2085 Fax: 501-682-3543  
Web: dentalboard.arkansas.gov Email: asbde@arkansas.gov



## Application for License to Practice Dentistry

Please type. Handwritten applications will not be accepted.

For Board Use:  
Lic. #: \_\_\_\_\_  
DOL: \_\_\_\_\_

### A. Personal Data

First Name	Middle Name	Maiden Name	Last Name	Degree
Address: (Street or PO Box)		City	State	Zip
Social Security Number		Home Phone #	Business Phone #	
Email Address	Date of Birth	Present Age	Place of Birth	
I am a citizen of the United States by (check one): <input type="checkbox"/> Birth <input type="checkbox"/> Naturalization <input type="checkbox"/> I am not a U.S. citizen.				
Height	Weight	Sex	Race	Marital Status
Mother's Name		Mother's Address	Mother's Occupation	
Father's Name		Father's Address	Father's Occupation	
Has your last name ever changed? _____ If so, when and from what? _____				

### B. Other State Dental Licenses

I am (or have been) licensed to practice Dentistry in the following states/jurisdictions:

State/Jurisdiction	How licensed	License Number	Date Licensed	Years of Practice

### C. Education

HIGH SCHOOL EDUCATION:			
Name of High School	City and State		Date of Graduation
COLLEGE EDUCATION:			
Degree	Name of School	City and State	Date of Graduation
DENTAL EDUCATION:			
Degree	Dates Attended	School	Date of Graduation
GRADUATE WORK/INTERNSHIP:			
School	Dates	Degree/Field	
List any other professional licenses you hold or have held:			

Arkansas is a member of the Southern Regional Testing Agency (SRTA). Please give all dates and locations where you have tested with SRTA, including the date you successfully completed all sections. Otherwise, indicate when and where you plan to take the examination:

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Have you successfully passed the National Board Examination? \_\_\_\_\_ Date: \_\_\_\_\_  
 If you have not already done so, please have the ADA send your National Board card directly to this office.

If licensed to practice Dentistry in Arkansas, when and where do you plan to practice?

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List any professional societies or organizations that you belong to:

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## D. Background History

If you answer "yes" to any of the following questions, please attach a detailed explanation.

Have you ever been charged with, or convicted of a felony?  Yes  No

Have you ever been charged with, or convicted of, been a party to, or been disciplined for violation of the dental laws of this or any other jurisdiction or professional association?  Yes  No

Are you, or have you ever been, addicted to the use of alcohol, controlled substances or other dangerous drugs?  
 Yes  No

Please list two (2) character references (neither of whom is related to you):

Name	Address	Occupation

## E. Physician's Statement of Examination of Applicant

I, \_\_\_\_\_, a duly licensed and practicing physician in the State of \_\_\_\_\_, have this day examined \_\_\_\_\_ the applicant herein, and my medical examination reveals that such applicant is free from all infectious and contagious diseases, and such applicant is in sound and good health. This examination made in (town) \_\_\_\_\_ on (date) \_\_\_\_\_, \_\_\_\_\_.

\_\_\_\_\_  
*Signature of Physician*

In addition to the foregoing:

1. I hereby give my permission for the Arkansas State Board of Dental Examiners to secure information concerning me or any of the statements in this application from any person or any source the Board may desire.
2. I further agree to submit to questions concerning my qualifications as an applicant by the Board or any member thereof, and to substantiate my statements if desired by the Board.
3. I have attached a check or money order in the amount of **\$150.00** to cover the application fee. I understand that this fee will be returned only if the Arkansas State Board of Dental Examiners does not accept this application. I have also attached a photograph taken of me within the last six months.
4. I agree to read the Dental Practice Act of Arkansas and the Rules & Regulations of the Board pertaining to Dentistry and Dental Hygiene; and I further state that all facts, statements, and answers contained in this application are true and correct; I am not omitting any information which might be of value to this Board in determining my qualifications, whether it is called for or not; and I agree that any falsification, omission or withholding of pertinent information or facts concerning my qualifications as an applicant shall be sufficient to bar me from licensure by the Arkansas State Board of Dental Examiners and such falsification, omission, or withholding shall serve as sufficient grounds for the revocation, cancellation, or suspension of my Arkansas Dental license if it is not discovered until after issuance.

\_\_\_\_\_  
Signature of Applicant