



ARKANSAS STATE BOARD OF DENTAL EXAMINERS

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Little Rock, Arkansas 72201
Phone: 501-682-2085 Fax: 501-682-3543
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*Place
Application
Photo
Here*

Application for Dental License by Credentials

Please type using Adobe Acrobat. Handwritten applications will NOI be accepted.

For Board Use:
Lic. #: _____
DOL: _____

Personal Data

First Name	Middle Name	Maiden Name	Last Name	Degree
Home Address: (Street or PO Box)		City	State	Zip
Business Address: (Street or PO Box)		City	State	Zip
Social Security Number	DEA Number	Home Phone #	Business Phone #	
Date of Birth	Present Age	Place of Birth	Email Address	
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? _____				

Other State Dental Licenses

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

State/Jurisdiction	Method of Licensure (i.e examination, credentials)	License Number	Date Licensed	# of Years of Practice

Education

COLLEGE EDUCATION:			
Degree	Dates Attended	School	Location
DENTAL EDUCATION:			
Degree	Dates Attended	School	Location
GRADUATE WORK/INTERNSHIP:			
School	Dates	Degree/Field	
List any other professional licenses you hold or have held:			

When did you successfully complete the National Board Examination? _____
 If you have not already done so, please have the ADA send your National Board card directly to this office.

When and where did you successfully complete a dental clinical examination? _____
 Results of the clinical exam must be sent directly to the Board from the state or regional testing agency that administered the examination.

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

List any professional societies or organizations that you belong to: _____

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 (city) _____ on (date) _____, _____.

Signature of Physician: _____

3. Make a complete statement of the general character of your practice in dentistry since first being licensed to practice in any jurisdiction. Include military or temporary work.

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4. Give the following information on three persons in each locality where you practiced dentistry with whom you are personally acquainted:

Name	Address	Occupation	# of Years Known

5. List three dentists who you know personally. These should be persons other than those listed in question #4):

Name	Address	Type of Practice	# of Years Known

6. Give the name and location of each dental association of which you are now or have ever been a member.

Name	Location

7. Give a detailed statement regarding any service in the armed forces, including branch of service, dates of active service, rank, serial number, locations, last commanding officer, and your last service address. If separated from service, state the nature of separation and if other than honorable, specify type thereof and circumstances surrounding your release. If applicable, give full particulars as to any formal complaints or disciplinary proceedings against you while serving in the armed forces.

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8. List liability insurance carriers – past and present. Give carrier name, location, coverage dates (from/to), and amount of coverage. List the nature of and the amount of malpractice payments made by any carrier.

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9. Have you ever held a bonded position?

<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>If "yes", specify the nature of that position, dates, amount of bond, and whether or not anyone ever sought to recover upon your bond or to cancel the same. State the facts fully, including the name and address of the bonding company.</i>
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10. Have you ever been suspended from practice, reprimanded, censured or otherwise disciplined or disqualified as a dentist or as a member of any professional organization, or as a holder of any office (public or private)?

<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>If "yes", state the dates, facts, disposition of the matter, and the name and address of the authority in possession of the applicable record:</i>
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11. Have any complaints or charges (formal or informal) ever been made or filed or proceedings instituted against you?

<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>If "yes", state the dates, facts, disposition of the matter, and the name and address of the authority in possession of the applicable record:</i>
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12. If you answer "yes" to any of the following questions, give full details including dates, exact name and location of courts, case numbers, references to the court records, and the facts and disposition of the matter. If no court records are available, give to the best of your ability the names and addresses of all persons involved, including counsel.

Have you in an individual capacity, ever been a party to or claimed any interest in any legal proceeding (civil or criminal) including professional liability?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>Explain:</i>
Have you ever been charged, arrested, or questioned regarding the violation of any law (except minor traffic violations)?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>Explain:</i>
Have you ever been charged with fraud (formally or informally) in any civil or criminal legal proceeding, or in bankruptcy?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>Explain:</i>
Have you ever been declared a ward of any court?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>Explain:</i>

Have you ever been adjudicated an incompetent or insane person by any court?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>Explain:</i>

Have you ever been adjudicated bankrupt, or has a petition in bankruptcy been filed at any time by you or against you, either alone or in any type association with others? Have you ever been brought in as a party to any proceedings in a bankruptcy court? Have you ever been sued or threatened with suit by the receiver, trustee, or other authority of any bankrupt estate for unlawful preference, conspiracy to conceal assets, or any other fraud or offense, whether punishable by criminal law or not?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>Explain:</i>

13. Were you ever dropped, suspended, or expelled from any school or college?

<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>Explain:</i>
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14. Have you ever been a voluntary patient in any sanitarium, hospital, or mental institution for the treatment of a mental illness?

<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>Explain:</i>
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15. Are you now (or have you ever been) addicted to narcotics, drugs and/or alcohol? Have you undergone treatment for the addiction(s)?

<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>Explain:</i>
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16. Are there any unsatisfied judgments against you? If yes, list details, giving amounts, dates, and the nature of the judgments and the reason for nonpayment.

<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain:
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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 **\$2250.00** to cover the application fee. I understand that this fee is non-refundable.
4. I attest that I have actively practiced dentistry for a minimum of **1000 hours per year** for the two calendar years immediately prior to the date of application. I further attest that the qualifying hours of clinical practice have been performed in the most current jurisdiction from where my application is being made.
5. I agree to read the Arkansas Dental Practice Act, Dental Corporation Act, and the Rules & Regulations of the Board pertaining to Dentistry and Dental Hygiene and to abide by these Statutes and Rules, and to take and pass (75%) the Arkansas Jurisprudence Examination.
6. I intend to practice in the State of Arkansas **within one year** of receiving my Arkansas dental license.
7. I further state that all facts, statements, and answers contained in this application and other documents 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 grounds for the revocation, cancellation, or suspension of my Arkansas Dental license if it is not discovered until after issuance.

Signature of Applicant