

Arkansas State Board of Dental Examiners
101 East Capitol Avenue, Suite 111
Little Rock, Arkansas 72201
(501) 682-2085

Application for Reinstatement: DDS _____ RDH _____

---- Print or type the following ----

Name: _____ **Date of Birth:** _____

Address: _____

_____ **Phone:** _____

Social Security #: _____ **DEA #:** _____

AR License #: _____ **Date Issued:** _____

To apply for reinstatement of your former license, send your annual renewal fees for the years missed plus \$200, your CE certificates, copy of your current CPR card, and this form which has been completed and signed. Have each state where licensed, whether active or not, send a letter of good standing directly to the Board. Use separate paper if more room is needed.

1. List in chronological order (most recent first) the places where you have practiced since your license was issued. If time was served in the military, it may be listed under one entry, as if all was served in one location.

CITY

STATE

WHEN

2. List, in the same order as in #1, a person located in each area who could verify your active practice.

NAME

ADDRESS

CITY, STATE, ZIP

3. List below any professional license you have ever held or now hold and specify whether it is current, lapsed, revoked, etc.

LICENSE # & KIND

STATE

STATUS OF LICENSE

IF ANY QUESTION BELOW IS "YES", explain fully on separate paper.

4. Have you ever been suspended from practice, reprimanded, censured or otherwise disciplined or disqualified as a dentist or dental hygienist, holder of any public or private office; or have any complaints or charges ever been filed or proceedings instituted against you? YES _____ NO _____

5. Have you ever been charged with, arrested, or questioned regarding a violation of any criminal or civil law, except a minor traffic violation? YES _____ NO _____

6. Have you ever had a malpractice charge filed against you, or your dental employees, or associates? YES _____ NO _____

7. Have you ever been involved in any civil or criminal legal proceeding not yet listed, or in bankruptcy? YES _____ NO _____

In addition to the foregoing:

I hereby give my permission for the Arkansas State Board of Dental Examiners to secure information concerning me on any of the statements of this application from any person or source the Board may desire.

I further agree to submit to questioning by the Board concerning my foregoing statements and to substantiate my statements if requested to do so. The providing of false or fraudulent information is grounds for imposition of the penalties set forth in A.C.A. 17-82-316.

I agree to read the Arkansas Dental Practice Act, Dental Corporation Act, and Rules and Regulations of the Board, to abide by these Statutes and Rules, and to take and pass (75%) the current Arkansas jurisprudence examination.

Signature: _____ **Date:** _____

You will be notified if and when your license has been reinstated and until then, you may not practice in Arkansas.

Renewal fees:	Dentist	Dental Hygienist	Clinically related CE hours
2004-2005	\$300	\$100	
2003	\$150	\$ 50	Dentists: 40 hours
2002	\$100	\$ 50	Hygienists: 30 hours
1997-2001	\$ 75	\$ 35	
1992-1996	\$100	\$ 50	
1982-1991	\$ 60	\$ 40	
1979-1981	\$ 40	\$ 20	