## APPLICATION FOR TEMPORARY LICENSE - DENTISTRY

Access this form via website at: **cca.hawaii.gov/pvl/boards/dentist**

**NOTE**: For your information, no person applying for a temporary license pursuant to section 448-12(a), Hawaii Revised Statutes ("HRS"), shall have the benefit of a temporary license if the licensure examination has been failed. This requirement is not applicable to those applying pursuant to section 448-12(b), HRS.

## SOCIAL SECURITY NUMBER

Your Social Security Number is used to verify your identity for licensing purposes and for compliance with the below laws. **For a license to be issued you must provide your Social Security Number or your application will be deemed deficient and will not be processed further.** The following laws require that you furnish your Social Security Number to our agency:

FEDERAL LAWS:
**42 U.S.C.A. §666(a)(13)** requires the Social Security Number of any applicant for a professional license or occupational license be recorded on the application for license; and
If you are a licensed health care practitioner, **45 C.F.R., Part 61, Subpart B, §61.7** requires the Social Security Number as part of the mandatory reporting we must do to the Healthcare Integrity and Protection Data Bank (HIPDB), of any final adverse licensing action against a licensed health care practitioner.

HAWAII REVISED STATUTES ("HRS"):
**§576D-13(j), HRS** requires the Social Security Number of any applicant for a professional license or occupational license be recorded on the application for license; and
**§436B-10(4), HRS** which states that an applicant for license shall provide the applicant's Social Security Number if the licensing authority is authorized by federal law to require the disclosure (and by the federal cites shown above, we are authorized to require the Social Security Number).

## INSTRUCTIONS

1. Complete and sign the on-line fillable application form or print legibly in dark ink.

   • Failure to provide the requested information will delay the processing of your application.

2. **ATTACH** non-refundable application fee of $75 for dentists or $50 for dental hygienists.
   Make check payable to: "Commerce and Consumer Affairs". (check must be in U.S. dollars and be from a U.S. financial institution.)
   A $25.00 service charge shall be assessed for payments dishonored for any reason. Should payment for temporary license be dishonored, the original issuance date is voided and new issuance date is issued upon payment of the new fees.

3. **SUBMIT** required documents: Diploma from a school accredited by the American Dental Association Commission on Dental Accreditation ("CODA"); National Board Scores Report; license verification(s), if applicable; and National Practitioner Data Bank report (if licensed anywhere).

4. **ATTACH** a letter of appointment prepared by your prospective qualified employer giving specific employment dates. Qualified employers include the State or any county or any legally incorporated eleemosynary dispensary or infirmary, private school, or welfare center.

5. Mail or deliver to:
   Board of Dentistry
   Commerce & Consumer Affairs, PVL
   335 Merchant Street, Room 301, P.O. Box 3469
   Honolulu, HI 96801
   Phone: (808) 586-3000

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| | | |
|---|---|---|
| Legal Name (First, Middle) | (Last) | |
| Other Names used: | | |
| Residence Address (Include Suite No., City, State and Zip Code) - **REQUIRED** | | |
| Mailing Address (Only if different from above) | | |
| Name & Address of Prospective Employer | | |
| Social Security Number | Phone No. (Days) | Date of Birth |

FOR OFFICE USE

| | |
|---|---|
| APPROVED: ☐ | Date: |
| License No. | Effective Date: |
| Employer Code: XXX - | Expiration Date: |

Type of License (Check one):

☐ DENTIST ☐ DENTAL HYGIENIST

Check answers; provide details when required:

1. Are you at least 18 years of age? ..... ☐ YES ☐ NO
2. Are you a U.S. citizen, a U.S. national, or an alien authorized to work in the United States? ..... ☐ YES ☐ NO
3. Are you a graduate of an ADA accredited dental program? ..... ☐ YES ☐ NO
4. Are you enrolled in a post-doctoral residency program accredited by CODA? ..... ☐ YES ☐ NO
5. Have you taken and passed all parts of the National Board Examination? ..... ☐ YES ☐ NO
6. Have you taken and passed the American Board of Dental Examiners dental licensing examination (ADLEX)? ..... ☐ YES ☐ NO
   Provide date you requested verification to be sent to our office: _____
7. Do you presently hold or have you ever held a license in any other state or country? ..... ☐ YES ☐ NO
   Where? _____ License #: _____
8. Has any license ever been suspended, revoked or otherwise subject to disciplinary action? ..... ☐ YES ☐ NO
9. Are there any disciplinary actions pending against you? ..... ☐ YES ☐ NO
   ***(If "YES" to questions 8 or 9, explain on separate sheet and arrange to have certified documents sent to the Board.)***
10. Have you ever been convicted of a crime in any jurisdiction that has not been annulled or expunged? ..... ☐ YES ☐ NO
    ***(If "YES", explain on separate sheet and attach court documentation on date, place, violation of each conviction and fulfillment of conditions of each sentence.)***
11. Have you ever had or have pending legal or regulatory action relating to claims of malpractice, or personal or professional misconduct? ..... ☐ YES ☐ NO
    ***(If "YES", explain on separate sheet and attach appropriate documents.)***

(CONTINUED ON PAGE 3)





Appl.....168..... $75/$50
Service Charge..... BCF..... $25

Name of Applicant (Dentist): _____ Date: _____

| EDUCATION | Dates (mo/yr) From | Dates (mo/yr) To | Semester or Credit Hours | Degree Earned & Date Earned | Name of Institution | Location (City/Country) |
|---|---|---|---|---|---|---|
| | | | | | College/University (other than dental) | |
| | | | | | Dental | |
| | | | | | Graduate | |

AFFIDAVIT OF APPLICANT:

I have carefully read the questions in the foregoing application and have answered them truthfully and completely, without reservations of any kind. I hereby authorize educational and other institutions, employers (past and present), business and professional associates (past and present), and all governmental agencies and instrumentalities (local, state, federal or foreign), to release to the Board of Dentistry of the State of Hawaii any information, files or records requested by the Board in connection with the processing of this application.

I hereby expressly waive all provisions of law forbidding any physician or other person who has attended or examined me, or who may hereafter attend or examine me, from disclosing any knowledge or information which is thereby acquired, and I hereby consent that any knowledge or information be disclosed to the Board of Dentistry in the State of Hawaii.

I hereby certify that the statements, answers, and representations made in this application and in the documents submitted are true and correct. I understand that any misrepresentation is grounds for refusal or subsequent revocation of license and is a misdemeanor (Section 710-1017, Sections 436B-19, and 448-17, Hawaii Revised Statutes).

I further certify that I have read, understand, and agree to the provisions of Chapter 448, Hawaii Revised Statutes, and Chapter 79, Hawaii Administrative Rules.

_____ _____

Signature Date

**Release of Information to Third Party:**

To assist me in the licensing process, I authorize the Board of Dentistry and staff to release any and all information regarding my application (including but not limited to, application status, examination scores, disciplinary or criminal history, National Practitioner Data Bank Report) to the following third party:

Name of Individual who is assisting you: _____

_____ _____

Signature of Applicant Date

Print Form

This material can be made available for individuals with special needs. Please call the Licensing Branch Manager at (808) 586-3000 to submit your request.