

## REQUIREMENTS & INSTRUCTIONS FOR LICENSURE - TEMPORARY DENTIST

Access this form via website at: [cca.hawaii.gov/pvl/boards/dentist](http://cca.hawaii.gov/pvl/boards/dentist)

Applications may be mailed hard-copy to our office or submitted online by creating a MyPVL account at: [mypvl@dcca.hawaii.gov](mailto:mypvl@dcca.hawaii.gov)

**NO EXAM RESTRICTION** There are no examination restrictions for individuals applying for temporary dentist licensure pursuant to Hawaii Revised Statutes (“HRS”) §448-12(b) as post-doctoral residents - i.e. such individuals may pass/fail the INBDE and/or ADEX and still qualify for and maintain temporary dentist licensure while applying for/enrolled in a qualifying post-doctoral dental residency program in Hawaii.

**Note:** Please contact your residency program directly if the program has any additional exam requirements to qualify for residency.

**APPLICATION** Complete the online fillable application form or print legibly in dark ink and sign application. Applicants are subject to requirements in effect at the time of application. Incomplete application information may delay processing of your application.

**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).

**FEES** Submit the appropriate amount made payable to: “Commerce & Consumer Affairs.” Check must be in U.S. dollars and be from a U.S. financial institution.

The application fee is non-refundable.

Temporary Dentist Post-Doc Residents license application fee - \$75

- **Note:** A \$25 service charge shall be assessed for payments dishonored for any reason. Should payment be dishonored, the original issuance date is voided and new issuance date is issued upon payment of the new fees.

**EDUCATION** Applicants must be a graduate of a dental college accredited by, or that has a reciprocal agreement with, the American Dental Association (“ADA”) Commission on Dental Accreditation (“CODA”) that is recognized and approved by the Board.

- **Note:** To date, only dental colleges accredited by the Commission on Dental Accreditation of Canada (“CDAC”) have such a “reciprocal agreement” with ADA CODA. If your dental education was outside the US, please contact CODA directly to confirm whether your foreign dental college has such a “reciprocal agreement.”

**SUBMIT:** To verify your qualifying education, you may self-submit any one (1) of the following:

1. Certified copy of diploma; or
2. Official transcripts; or
3. Signed letter from the Dean of the school/Registrar’s office sent directly from the school certifying that you have graduated, including:
  - Date of matriculation
  - Official date of graduation
  - Confirmation of graduating with a DDS or DMD degree

**RESIDENCY PROGRAM LETTER**

Your program director must submit one letter for all residents in the upcoming program cycle confirming enrollment in the post-doctoral residency program.

**The letter must meet the following requirements:**

- Be signed
- Be on official letterhead
- List your legal first and last name
- Confirm the start and end dates of the residency program
- List your assigned training site(s) for the program
- **Note:** If your program has an “optional” additional year and you choose to enroll in the additional year, your program director will need to submit a new letter to confirm the new end date of your enrollment.
- **Note:** Pursuant to HRS 448-12(c), post-doc residents who are granted temporary licenses shall:
  1. Be assigned to affiliated training sites that are restricted to eleemosynary health care organizations, training site hospitals, or university-affiliated training programs, and that shall be visited and accredited by the Commission on Dental Accreditation of the American Dental Association, consistent with the policies of the Commission on Dental Accreditation of the American Dental Association; and
  2. Act under the direct supervision of the dental residency faculty licensed in Hawaii.

**NATIONAL PRACTITIONER DATA BANK (“NPDB”) VERIFICATION**

Applicants who are licensed in another state or U.S. territory are directed to call the Data Bank Customer Service Center at: 1-800-767-6732 or to go online at <https://www.npdb.hrsa.gov/ext/selfquery/SQHome.jsp> for information on ordering a “Self-Query Report.”

**SUBMIT:** Original report titled “Self-Query Response” to our office.

**LICENSE VERIFICATION**

On the application, list all the dentist licenses you hold or have previously held at any time.

**SUBMIT:** If licensed in any other jurisdiction, arrange for all applicable jurisdictions to complete the “Verification of License” form (DT-14a) and have it sent directly to the Hawaii Board of Dentistry. Some jurisdictions may charge a fee for verification service. Contact the appropriate licensing agency for information on verification requirements. The applicant is responsible for any fees incurred. Applicants may not self-submit license verification.

- **Note:** Verifying boards can mail license verifications using the mailing address below, or send via email to [Dental@dcca.hawaii.gov](mailto:Dental@dcca.hawaii.gov)

**TERMINATION OF LICENSE VALIDITY**

Pursuant to HRS §448-12(b), the temporary license shall authorize the person to whom the license is issued to practice dentistry exclusively under the auspices of the dental residency program.

The temporary license shall only be valid until the earliest of the following occurs:

1. The date you complete or leave the residency program; or
2. The date on which the Board revokes the temporary license; provided that the Board may revoke the temporary license at any time for cause.

- **Note:** Residency program directors and licensees shall inform the Board’s office of any early termination of a resident’s enrollment in a qualifying post-doctoral residency program.

**RELEASE OF INFORMATION**

If an agency or individual is assisting you with the licensure process, we will not be able to release any information to them unless you provide us with authorization. If you wish to do so, please complete The “Release of Information to Third Party” section at the end of the application form.

**ADDRESS OF THE BOARD**

Mail all required items to: DCCA-PVL Attn: Dental P.O. Box 3469 Honolulu, HI 96801	OR	Deliver to office location at: 335 Merchant St. Room 301 Honolulu, HI 96813 (808) 586-3000
--	----	--

## LAWS & RULES

A copy of the laws, Chapter 448 (dentists) and Chapter 447 (dental hygienists), Hawaii Revised Statutes, and rule, Chapter 79, Hawaii Administrative Rules, relating to the practice of dentistry may be obtained by submitting a written request to the mailing address above. Chapter 436B, Hawaii Revised Statutes, the Professional and Vocational Licensing Act should be read in conjunction with Chapters 448, 447, and 79.

The laws & rules are also posted on the Board's website at: <https://cca.hawaii.gov/pvl/boards/dentist/>.

## ABANDONMENT OF APPLICATION

Pursuant to HRS §436B-9, your application shall be considered abandoned and will be destroyed if you fail to complete the license process within one (1) year after filing an application.

If an application is deemed abandoned, the applicant shall be required to reapply for licensure and comply with the licensing requirements at the time of the reapplication.

---

## SUBMITTALS

The following should be submitted for a complete application for temporary dentist licensure as a post-doctoral resident. All applications and submittals are subject to the requirements set forth by the Board's laws and rules.

1. Application form and fees;
2. Verification of education:
  - a. Certified copy of diploma - self-submit; or
  - b. Official transcripts - self-submit; or
  - c. Letter from the Dean/Registrar's office that meets the above requirements - must be sent directly from the school to Hawaii
3. NBDP self-query (if licensed in another jurisdiction) - self-submit
4. License verification (for every jurisdiction currently AND previously licensed in) - sent directly by the verifying board of each jurisdiction to Hawaii
5. Letter confirming residency by program director:
  - a. Signed, dated, on official letterhead
  - b. States the start and end dates of the residency program
  - c. Lists your assigned training site(s)

**APPLICATION FOR TEMPORARY LICENSE - DENTIST (RESIDENCY ONLY)**

Access this form via website at: [cca.hawaii.gov/pvl/boards/dentist](http://cca.hawaii.gov/pvl/boards/dentist)

Legal Name (First)			(Middle)	(Last)	FOR OFFICE USE	APPROVED: <input type="checkbox"/>	Date:
Other Names used:						License No.	Effective Date:
Residence Address (Include Suite No., City, State and Zip Code) - <b>REQUIRED</b>						Employer Code: XXX -	Expiration Date:
Mailing Address (Only if different from above)							
Name & Address of Residency Program							
Social Security Number	Phone No. (Days)	Date of Birth				Email Address:	

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 or a dental program that has a reciprocal agreement with ADA CODA? .....  YES  NO
4. Are you enrolled in a CODA accredited post-doctoral residency program in Hawaii? .....  YES  NO
5. Do you presently hold or have you ever held a license in any other state? .....  YES  NO  
List state(s) with license number: \_\_\_\_\_
6. Has your residency program director submitted an enrollment letter to our office on your behalf? .....  YES  NO
7. Has any license ever been suspended, revoked, or otherwise subject to disciplinary action? .....  YES  NO  
(If "yes," submit a signed letter of explanation and any official court, board, or other documentation)
8. Are there any disciplinary actions pending against you? .....  YES  NO  
(If "yes," submit a signed letter of explanation and any official court, board, or other documentation)
9. Have you ever been convicted of a crime in any jurisdiction that has not been annulled or expunged? .....  YES  NO  
(If "yes," submit a signed letter of explanation and any official court or other legal documentation verifying fulfillment of the sentencing requirements)
10. Have you ever had or have pending legal or regulatory action relating to claims or malpractice, or personal or professional misconduct? .....  YES  NO  
(If "yes," submit a signed letter of explanation and appropriate documents)

(CONTINUED ON PAGE 3)

Name of Applicant (Dentist): \_\_\_\_\_

Date: \_\_\_\_\_

	Dates (mo/yr)		Degree Earned & Date Earned	Name of Institution	Location (City/Country)
	From	To			
<b>EDUCATION</b>				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 447, Hawaii Revised Statutes, Chapter 448, Hawaii Revised Statutes, Chapter 436B, Hawaii Revised Statutes, and Chapter 79, Hawaii Administrative Rules.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**Release of Information to Third Party (Optional):**

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