**West Virginia Board of Dentistry**
**1319 Robert C. Byrd Drive**
**PO Box 1447**
**Crab Orchard, WV 25827-1447**

FOR OFFICE USE ONLY

AADB Clearinghouse _____

# APPLICATION FOR SPECIAL VOLUNTEER DENTAL LICENSE

**Applicant Identifying Information**
**Complete this section by providing all requested information. You must notify the Board office, in writing, of any address changes after you file this application in order to receive additional information.**

Applicant's Name _____
Last First Middle Suffix (Jr., III)

If Married, maiden name (if applicable)_____ Name of Spouse _____

Name desired on license (if granted). _____

U.S. Citizen:_____ Yes _____ No _____ **I am not a U. S. Citizen** but am a qualified alien under the federal Immigration and Naturalization Act, and I am lawfully present in the United States. ***Submit copy of Green Card or Visa.**

Preferred Mailing Address_____
Street City County State Zip

Home Address_____
Street City County State Zip

Home Phone ( )_____ Cell ( )_____

_____ _____ _____ _____
Place of Birth (City, State or Country) Date of Birth MM/DD/YYYY Gender M/F Race

*Social Security Number: _____

*The Social Security Number is not subject to disclosure as public information. The disclosure of the SSN for identification purposes is authorized and mandated by federal statutes requiring state dental boards to report to the Healthcare Integrity and Protection Data Bank and the National Practitioner Data Bank.

Military Service: _____ Dates of Service: _____
Branch of Service

Honorable / Dishonorable Discharge: _____ If other than Honorable, attach a copy.

Application must be completed with all requested information and documentation supplied *The application form is a public document subject to the Freedom of Information Act.*

**II. Education Information**

**Pre-Dental & Dental College, School or Dental Department of a University**

| | Name of School | Location (City, State or Country) | From (Month/Year) | To (Month/Year) | Graduated Yes/No | Degree |
|---|---|---|---|---|---|---|
| Pre-Dental | | | | | | |
| Dental | | | | | | |
| Internship or Residency | | | | | | |
| Other | | | | | | |

**III. Record of Licensure Information**

**List all states in which you have ever been licensed, whether currently active or not. Failure to disclose all licenses held may result in denial of your application.**

| State | Date Issued | License No. | Expiration Date | Active or Inactive |
|---|---|---|---|---|
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## IV. Personal History Information

**Please respond to all questions. If you answer "yes" to any question, you must attach a written explanation. In addition, if you answer "yes" to any question, you may be requested to appear before the Board to answer additional questions and/or provide additional information.**

| | | Circle One | |
|---|---|---|---|
| 1. | During any professional/dental education, were you ever dismissed, suspended, restricted, disciplined, placed on probation, or otherwise acted against or did you take a leave of absence ? | Yes | No |
| 2. | During any professional/dental education, were you ever requested to leave or did you leave, temporarily or permanently, prior to completion of training? | Yes | No |
| 3. | Have you ever had an application for a license/certificate in any health care profession refused or denied by any licensing board, regulatory agency, health care facility or other entity? | Yes | No |
| 4. | Have you ever had any written complaint, formal accusation, final order, disciplinary action, malpractice or consent order filed against you by any person, jurisdiction, licensing board or regulatory agency? | Yes | No |
| 5. | Have you ever been arrested, charged or convicted, pled guilty or pled nolo contendere for violation of any federal, state, or local law (other than a minor traffic violation)? (DWI & DUIs are **not** minor traffic violations). (Although a conviction may have been expunged from the records by order of the court, it nevertheless must be disclosed in your answer). **You must attach the court disposition.** | Yes | No |
| 6. | Are you currently under investigation or the subject of pending disciplinary action by any licensing board, regulatory agency, health care facility or other entity? | Yes | No |
| 7. | Currently or within the last five years, have you been treated for any physical, mental or emotional condition that might interfere with your ability to competently and safely perform the essential functions of practice? | Yes | No |
| 8. | Currently or within the last five years, have you been treated for drug or alcohol addiction that might interfere with your ability to competently and safely perform the essential functions of practice? | Yes | No |
| 9. | Currently or within the last five years, have you developed any disease or condition, physical, mental or emotional, that might interfere with your ability to competently and safely perform the essential functions of practice? | Yes | No |

Have you ever been known by any name(s) other than what is listed above? _____ Yes _____ No.

If yes, state in full every other name by which you have been known. If change was made by a Court Order, enclose copy.

_____

_____

_____

I plan to volunteer at _____. I have attached the written agreement, as required by law, §30-4-8a, with the clinic and their proof of insurance.

**Please list your addresses and occupations for the past ten years. Please complete this section, whether or not you were employed. List in chronological order.**

| From Month/Year | To Month/Year | Employer | Office Address | Occupation/Type of Practice |
|---|---|---|---|---|
| | | | | |
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**Physician's Statement of Examination of Applicant**

I, _____, a duly licensed physician of the State of _____, have this day examined _____. The applicant herein, and my medical examination reveals that such applicant is free from all infectious, malignant, and contagious diseases, and such applicant is in sound and good health. Examination made in _____, State of _____, on the _____day of _____, 20____.

_____, MD/DO
Physician's Signature

**V. References**

**List below the names of two individuals supplying references of good moral character, neither of whom is related to you or is a teacher at any dental college you attended. Reference letters are to be sent directly to the Board by fax or U. S. Mail.**

| Name | Address | Occupation |
|---|---|---|
| 1. | | |
| 2. | | |

## VI. Attestation

In addition to the foregoing information, I add the following:

1. I will read the Dental Laws and Rules of West Virginia and intend to practice dentistry in keeping within the spirit and the letter of these laws.

2 My special volunteer dentist license will be exclusively devoted to providing dentistry or dental hygiene care to needy and indigent persons in West Virginia; I will not receive any payment or compensation, either direct or indirect, or have the expectation of any payment or compensation, for any dentistry services rendered under the special volunteer dentist license.

3. I will supply any supporting documentation that the board may reasonably require.

4. I agree to continue to participate in continuing professional education as required by the board for the special volunteer dentist.

5. I hereby give permission to the West Virginia Board of Dentistry to secure additional information concerning me or any of the statements in this application from any person or any source the Board may deem necessary. I release, discharge and exonerate the Board, or it's agents, and/or any person furnishing information about me from any and all liability of every nature and kind arising out of the furnishing of such information.

6. I further agree to submit to questioning by the Board or any member thereof, and to substantiate my statements when necessary.

7. I shall present all credentials and documents required or requested by the Board.

8. I, the undersigned, do hereby affirm under penalty of perjury that all statements made and information contained in this application are true and correct to the best of my knowledge and belief. Further, I consent to a thorough investigation of my employment record and other information that may be necessary to verify my qualifications to practice. I understand that any final disciplinary actions that may ever be taken against my license, if granted, would be provided to a national disciplinary reporting system and that my Social Security number would be a part of that report.

I certify that the foregoing information is true and correct to the best of my knowledge. I understand filing of false information may subject my license to disciplinary action including, but not limited to, revocation or suspension of my license.

_____ _____

Signature of Applicant Date

NOTARY

(**PHOTOGRAPH)**
**ATTACH A RECENT**
**PHOTOGRAPH HERE**

_____

Name of Applicant

County of _____ State of _____

Being duly sworn, says that he/she is the person who executed the above application for license to practice dentistry in the State of West Virginia, and that all the statements herein contained are true in every respect and that the attached photo is a true photo of the applicant.

_____

Notary Signature

**NOTARY: Do not notarize unless a photograph is attached.**

Sworn to and subscribed before me this _____ day of _____, 20____.

My Commission Expires _____ (SEAL)

You must supply a copy of the written agreement with the clinic and a statement that the clinic will be providing the malpractice insurance which is required by the new law, a copy of which is attached.

Please supply a copy of the following:

Copy of current Drivers license;

Copy of current CPR card; and

Copy of recent infection control continuing education certificates.

If not a US citizen, please provide a copy of the following:

Copy of US Immigration Services work authorization or permit.