

**OHIO STATE DENTAL BOARD
77 SOUTH HIGH STREET, 18TH FLOOR
COLUMBUS, OHIO 43215-6135
(614) 466-2580
FAX (614) 752-8995**

LIMITED CONTINUING EDUCATION LICENSE

4715.16 (C)(2)

"Upon payment of one hundred one dollars (\$101) and application endorsed by the director of a continuing dental education practicum, the state dental board shall, without examination, issue a temporary limited continuing education license to a resident of a state other than Ohio who is licensed to practice dentistry in such state and is in good standing, is a graduate of an accredited dental college, and is registered to participate in the endorsing practicum. The determination of whether a dentist is in good standing shall be made by the state dental board.

A dentist holding a temporary limited continuing education license may practice dentistry only on residents of the state in which he is permanently licensed or on patients referred by a dentist licensed pursuant to section 4715.12 or 4715.15 of the Revised Code to an instructing dentist licensed pursuant to one of those same sections, and only while participating in a required clinical exercise of the endorsing practicum on the premises of the facility where the practicum is being conducted.

Practice under a temporary limited continuing education license shall be under the direct supervision and full professional responsibility of an instructing dentist licensed pursuant to section 4715.12 or 4715.15 of the Revised Code, shall be limited to the performance of those procedures necessary to complete the endorsing practicum and shall not exceed thirty days of actual patient treatment in any year."

APPLICATIONS FEES ARE NONREFUNDABLE, EVEN IN THE EVENT THAT THE APPLICATION IS SUBSEQUENTLY DENIED OR WITHDRAWN.

Persons applying for a limited continuing education license are required ***to show proof of having been immunized against or having immunity to, the hepatitis B virus.***

4715-3-01 (T)

"Treatment day' - Any portion of any day during which treatment is rendered to a patient in a continuing education practicum constitutes a treatment day, according to section 4715.16 of the Revised Code."



OHIO STATE DENTAL BOARD

APPLICATION FOR A LIMITED CONTINUING EDUCATION LICENSE IN THE STATE OF OHIO

THE APPLICATION MUST BE COMPLETE AND THE APPROPRIATE FEE SUBMITTED BEFORE LICENSURE WILL BE CONSIDERED.

1. PRESENT LEGAL NAME	LAST	FIRST	MIDDLE	MAIDEN (IF APPLICABLE)	
2. ADDRESS	NUMBER AND STREET	CITY	STATE	ZIP CODE COUNTY	
NAME AS YOU WISH IT TO APPEAR ON YOUR LICENSE:					
3. PLACE OF BIRTH	CITY	STATE	COUNTY	<p>AN UNMOUNTED FRONT-FACE COLOR BUST PHOTOGRAPH OF APPLICANT, TAKEN NOT MORE THAN SIX MONTHS BEFORE THE DATE OF APPLICATION MUST BE PASTED IN THIS SPACE.</p> <p>APPLICATION OR PASSPORT TYPE PHOTO MUST BE USED.</p>	
DATE OF BIRTH	AGE	SEX	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		
4. SOCIAL SECURITY NO.					
5. PHYSICAL DESCRIPTION	COLOR OF HAIR	COLOR OF EYES			
BUILD	HEIGHT	WEIGHT			
MARKS					
6. LIST ALL THE NAMES OTHER THAN THE NAME GIVEN ABOVE THAT YOU HAVE USED. ALSO, INDICATE THE TIME PERIOD DURING WHICH YOU USED THE NAMES. BE SURE TO INCLUDE ALL NAMES. FAILURE TO DO SO MAY RESULT IN DENIAL. YOU MUST SUPPLY THE APPROPRIATE LEGAL DOCUMENT WHICH AUTHORIZES THE NAME CHANGE. THIS MAY BE A COURT DECREE OR A MARRIAGE CERTIFICATE.					
NOTE: INDIVIDUALS WHO RETAIN THEIR MAIDEN NAME OR HYPHENATE THEIR MAIDEN NAME AND MARRIED NAMES ARE REQUESTED TO BE CONSISTENT IN SUCH USAGE.					
OTHER NAMES USED			DATES USED		
			FROM MO/YR	TO MO/YR	
			MO/YR	MO/YR	
7. LIST THE NAME AND LOCATION AND DATE OF EACH CONTINUING EDUCATION PRACTICUM: _____					
8. DIRECTOR OF THE CONTINUING EDUCATION PROGRAM OF EACH PRACTICUM: _____					
PRE DENTAL EDUCATION					
9. COLLEGE/UNIV. ATTENDED	LOCATION	DEGREE	FROM MO/YR	TO MO/YR	
DENTAL EDUCATION					
10. NAME OF SCHOOL	LOCATION	NO. OF YRS.	FROM MO/YR	TO MO/YR DEGREE	

CERTIFICATE OF DENTAL COLLEGE

11. I HEREBY CERTIFY THAT _____ MATRICULATED IN _____
NAME OF APPLICANT

DENTAL COLLEGE ON _____, 19____. HE/SHE ATTENDED AND SUCCESSFULLY COMPLETED A FULL COURSE IN DENTISTRY AND GRADUATED WITH THE DEGREE OF DDS/DMD ON THE _____ DAY OF _____, _____. I FURTHER CERTIFY THAT I KNOW OF NO REASON WHY THE APPLICANT SHOULD NOT BE GRANTED A LIMITED CONTINUING EDUCATION LICENSE IN THE STATE OF OHIO.

SEAL

SIGNATURE OF DEAN _____ DATE _____

JURISDICTIONS IN WHICH APPLICANT IS LICENSED

12. I AM LICENSED TO PRACTICE DENTISTRY IN THE FOLLOWING JURISDICTIONS AND NO OTHERS:

JURISDICTION	HOW LICENSED	LICENSE NO.	DATE OF ISSUANCE	YEARS OF PRACTICE

13. I HAVE BEEN REFUSED DENTAL LICENSURE BY THE FOLLOWING JURISDICTIONS AND NO OTHERS, FOR THE FOLLOWING REASONS:

PRACTICE HISTORY

14. PROVIDE THE FOLLOWING CERTIFICATION AND MAKE A COMPLETE STATEMENT OF ALL YOUR PRACTICE SINCE GRADUATION TO DATE. INCLUDE TEMPORARY OR PART-TIME WORK. STATE AS TO EACH EMPLOYMENT OR PERIOD OF PRACTICE. (USE AN EXTRA SHEET OF PAPER, IF NECESSARY.)

A. THE PERIODS DURING WHICH YOU WERE EMPLOYED AS A DENTIST OR ENGAGED IN THE PRIVATE PRACTICE OF DENTISTRY, WITH THE DATES. _____

B. THE ADDRESS OF THE OFFICES OR PLACES AT WHICH YOU HAVE BEEN EMPLOYED OR ENGAGED, AND THE NAMES AND ADDRESSES OF ALL EMPLOYERS OR PARTNERS. _____

C. THE NATURE OF YOUR PRACTICE. (IF YOUR PRESENT PRACTICE IS LIMITED TO A SPECIALTY, LIST THE SPECIALTY.) _____

D. THE REASON FOR THE TERMINATION OF EACH EMPLOYMENT OR PERIOD OF PRIVATE DENTAL PRACTICE. _____

MEDICAL REPORT

15. I, _____, A DULY LICENSED PHYSICIAN IN THE STATE OF _____, HAVE THIS DAY EXAMINED _____, AND MY MEDICAL EXAMINATION REVEALS THAT TO THE BEST OF MY KNOWLEDGE, THE APPLICANT IS NOT DEPENDENT ON NARCOTIC DRUGS OR ALCOHOL. MOREOVER, I FIND THAT THE APPLICANT HAS NO PHYSICAL OR MENTAL DISABILITIES EXCEPT: _____.

THE EXAMINATION WAS MADE IN _____, STATE OF _____, ON THE _____ DAY OF _____, _____.

SIGNATURE OF PHYSICIAN _____

CERTIFICATE OF SECRETARY OF BOARD OF DENTAL EXAMINERS OF THE STATE IN WHICH APPLICANT IS CURRENTLY LICENSED

16. IF YOU ARE PRESENTLY LICENSED IN MORE THAN ONE STATE, PROVIDE THE FOLLOWING CERTIFICATION FROM THE LAST STATE IN WHICH YOU ATTAINED LICENSURE, OR THE ONE IN WHICH YOU NOW PRACTICE. (OTHER STATES SHOULD PROVIDE LETTERS OF CERTIFICATION.)

I, _____ SECRETARY OF _____ (OFFICIAL NAME OF BOARD) HEREBY CERTIFY THAT _____ WAS GRANTED STATE CERTIFICATE NUMBER _____ TO PRACTICE DENTISTRY IN THE STATE OF _____ ON THE _____ DAY OF _____, _____, ON THE BASIS OF _____ EXAMINATION OR _____ CRITERIA APPROVAL.

ACTING ON BEHALF OF _____, I HEREBY CERTIFY TO THE REPUTABILITY OF THE APPLICANT AS APPEARS ON RECORD IN THIS OFFICE, AND RECOMMEND HIM/HER TO THE OHIO STATE DENTAL BOARD AS A FIT AND PROPER PERSON TO RECEIVE A LIMITED CONTINUING EDUCATION LICENSE IN THE STATE OF OHIO. I FURTHER CERTIFY THAT I KNOW OF NO REASON WHY THIS APPLICANT SHOULD NOT RECEIVE A LIMITED CONTINUING EDUCATION LICENSE IN THE STATE OF OHIO.

DATE _____ SIGNATURE OF BOARD SECRETARY _____ **SEAL**

17. HAVE YOU BEEN ENTITLED TO PRACTICE IN EACH OF THE JURISDICTIONS SPECIFIED UNDER QUESTION 12, CONTINUOUSLY FROM THE DATE YOU FIRST BECAME ENTITLED UNTIL THE PRESENT? YES NO
IF NO, WHY? _____

18. HAVE YOU BEEN SUSPENDED FROM PRACTICE, REPRIMANDED, CENSURED, OR OTHERWISE DISCIPLINED OR DISQUALIFIED AS A DENTIST OR A MEMBER OF ANY PROFESSION? YES NO
IF YES, STATE THE DATES, THE FACTS, THE DISPOSITION OF THE MATTER AND THE NAME AND ADDRESS OF THE AUTHORITY IN POSSESSION OF THE RECORD THEREOF. (ATTACH STATEMENTS.)

19. **A:** HAVE YOU BEEN CONVICTED OF OR PLEAD GUILTY TO ANY FELONY OR MISDEMEANOR, INCLUDING DRIVING WHILE UNDER THE INFLUENCE OF ALCOHOL OR OTHER DRUGS? YES NO
IF YES, ATTACH STATEMENTS GIVING DATES AND DISPOSITION.

B: DO YOU HAVE ANY CRIMINAL CHARGES PENDING AGAINST YOU? YES NO
IF YES, ATTACH STATEMENT GIVING DETAILS OF THE MATTER AND THE NAME AND ADDRESS OF THE AUTHORITY IN POSSESSION OF THE RECORD THEREOF.

20. HAVE YOU EVER BEEN TREATED FOR MENTAL ILLNESS ON AN OUTPATIENT BASIS, OR BEEN CONFINED TO ANY SANITARIUM, HOSPITAL OR MENTAL INSTITUTION FOR THE TREATMENT OF MENTAL ILLNESS? YES NO
IF YES, ATTACH STATEMENTS GIVING FULL EXPLANATION, INCLUDING NAMES AND ADDRESSES OF THE DOCTORS AND INSTITUTIONS.

21. ARE YOU NOW, OR HAVE YOU EVER BEEN ADDICTED TO, OR HAVE YOU RECEIVED TREATMENT FOR, THE HABITUAL USE OF NARCOTICS OR ALCOHOL? YES NO
IF YES, ATTACH STATEMENT GIVING FULL EXPLANATION, DATES, PLACES, ETC.

22. ARE YOU CURRENTLY IMMUNE TO, OR HAVE YOU RECEIVED INOCULATION AGAINST THE HEPATITIS B VIRUS? YES NO
IF YES, PLEASE ATTACH DOCUMENTARY EVIDENCE OF SAME.
IF NO, YOU ARE REQUIRED TO SUBMIT PROOF OF IMMUNITY TO OR INOCULATION PRIOR TO COMMENCING PATIENT CONTACT.

