Ohio State Dental Board

77 South High Street, 18th Floor
Columbus, Ohio 43215-6135

Phone #: 614/466-2580
Fax #: 614/752-8995

www.dental.ohio.gov

DENTAL REINSTATEMENT INFORMATION

Dentists seeking reinstatement of their licenses from retirement or military exempt status, or suspension for failure to renew, will be required to submit the following information:

1. A completed application (enclosed).

2. A detailed resume of your dental practice since your retirement/suspension or military exemption.

   Dental applicants may be required to take a refresher course in their discipline and/or a clinical examination.

3. A check in the amount of $245/retired or exempt dentist, or $326/suspended dentist, made payable to the Ohio State Dental Board. The fee must be submitted either by **certified check or money order**. Personal checks will not be accepted. **ALL FEES ARE NONREFUNDABLE, EVEN IF THE REINSTATEMENT APPLICATION IS SUBSEQUENTLY DENIED OR WITHDRAWN**.

4. Applicants who are now or who have been licensed in another state must submit with the application the following:

   (a) A certification letter from **each** of the state board(s) of dental examiners where the applicant **holds or has held a dental license since retirement /suspension/ exemption** stating that the license is in good standing. The state board signing the application does not have to provide a separate letter.

5. Letters of reference from any dental associations of which you have been a **member** during the past five years.

6. Proof that you have completed forty (40) hours of continuing education during the preceding two years.

7. A Criminal Records Check completed by the Bureau of Criminal Identification and Investigation and must be submitted directly to the Board. Results shall be received by the Board prior to the issuance of a license to practice.

8. Proof of immunization against or immunity to the hepatitis B virus.

9. Pass a written jurisprudence examination on the Dental Practice Act, Chapter 4715. of the Ohio Revised Code. This examination is available on our website at www.dental.ohio.gov under jurisprudence exams or can be taken at the Board office by appointment, at a dental or dental hygiene school or state board office in Ohio or in another state, by special arrangement.

10. You might be required to appear at a regularly scheduled Dental Board meeting for an interview by the Board. You will be notified of the date and time of the next available interview **after** we receive your **completed** application.

If you have any questions concerning these instructions, please do not hesitate to call the board office.

Criminal Records Checks

Section 4715.101 of the Ohio Revised Code requires all individuals applying for a license issued by the Ohio State Dental Board (board) to submit fingerprints for a criminal records check completed by the Bureau of Criminal Identification and Investigation (BCI&I) and the Federal Bureau of Investigation (FBI).

INSTRUCTIONS FOR OHIO RESIDENTS

Applicants residing in Ohio are required to utilize "WebCheck" to electronically submit their fingerprints to BCI&I. The Board will typically receive the results of a criminal records check submitted via "WebCheck" within 7 to 10 business days. In addition to the $22 BCI&I fee and the $24 FBI fee, the electronic fingerprinting location may charge its own fee to process the fingerprints. Since the law requires applications for licensure to submit a records check completed by both BCI&I and FBI, you **must** use the services of a "WebCheck" vendor that participates in the "National WebCheck." The Sheriff's offices in all 88 counties participate in the "National WebCheck." A list of other "WebCheck" vendors in Ohio, arranged by county, is available online at: http://www.ohioattorneygeneral.gov/Services/Business/WebCheck/Webcheck-Community-Listing. When locating an electronic fingerprinting site on this web page, please note that you **must** use the services of a vendor that has "BCI & FBI" listed after the vendor's name as only these entities participate in "National WebCheck." You need both the BCI&I and FBI records check for initial licensure. By law, the board cannot complete the processing of your application until it receives the background check reports from both these entities.

Instructions for "WebCheck"

1. Identify a "WebCheck" vendor that participates in the "National WebCheck" and contact that location for specific instructions.
2. Submit the required fee directly to the "WebCheck" vendor. **DO NOT SEND YOUR FINGERPRINTS OR FEE TO THE BOARD.**
3. Request that the criminal records check results from both BCI&I and FBI be sent directly to:
   Ohio State Dental Board
   77 S High St., 18th Floor
   Columbus, OH 43215-3135
4. List the reason for fingerprinting as: "Required for licensure per ORC 4715.101

INSTRUCTIONS FOR OUT-OF-STATE RESIDENTS

You must contact a local law enforcement agency to arrange for the required fingerprinting on two (2) fingerprint cards. This can only be accomplished by a law enforcement official who must sign and date the cards to verify the accuracy and authenticity of the prints. Any processing fees required for this service should be paid directly to the involved agency. Reminder: Fingerprints processed from out-of-state locations are processed much slower, up to 3 to 4 months, than electronic fingerprints taken within the State of Ohio. Additional delays can occur of the prints are unreadable or information is not complete. If time is extremely critical, you may want to consider submitting the prints electronically from an Ohio location. Should you choose to come to Ohio for your criminal records check, please see Instructions for Ohio Residents.

Instructions for completing the Fingerprint Card Process

1. Complete and send BOTH cards to BCI&I after you have been fingerprinted at a law enforcement agency.
2. Complete all the information above the solid blue lines in BLACK INK.
3. Write clearly, as unreadable cards will be rejected.
4. Do not alter the card or boxes.
5. For the FBI (applicant) card: **Race:** W (White); B (Black); A (Asian); I (American Indian/Alaskan Native American): U (Unknown.) **Eyes:** BLK (black); BLU (blue); BRO (brown); GRN (green); GRY (gray) or XXX (unknown.)
6. Make money order or cashier's check payable to Treasurer, State of Ohio. Submit $22.00 for the Civilian Background Check and $24.00 for the FBI Check for a total of $46.00.

IMPORTANT: SEND BOTH CARDS AND FEES TO BCI&I, PO BOX 365, 1560 STATE ROUTE 56 SW, LONDON, OHIO 43140 (740-845-2375.) DO NOT SEND CARDS AND FEES TO THE BOARD OFFICE.

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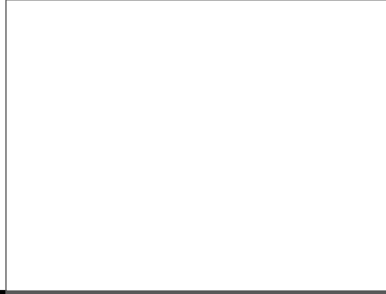

Do Not Write In This Space

APPLICATION FOR REINSTATEMENT OF DENTAL LICENSE

☐ SUSPENDED DENTIST
☐ RETIRED DENTIST

1. Present Legal Name (Print) Last First Middle Maiden (If applicable)

2. Address Number and Street City State Zip Code County

3. Telephone: Business Home E-Mail

4. Social Security No.

5. Intended Place of Practice Street Address City State Zip Code

Other State Licenses

6. I am/was licensed to practice dentistry in the following jurisdictions and no others:

Jurisdiction	How Licensed	License Number	Date of Issuance	Years of Practice

7. I have been refused dental licensure by the following jurisdictions and no others, for the following reasons:
____
____

Practice History

8. If you have been admitted to practice in any jurisdiction, 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 for dentist, or period of private dental practice.

____

____

Certificate of Secretary of Board of Dental Examiners of the State in which Applicant is Now Licensed (if other than Ohio)

9. 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 ______________,____________,

to the basis of ______examination or ______Criteria Approval.

Acting on behalf of ____________________, I hereby certify to the reputability of the applicant as appears
(Official Name of Board)
on record in this office, and recommend him/her to the Ohio State Dental Board as a fit and proper person to receive a license. I further certify that I know of no reason why this applicant should not be licensed to practice dentistry in the state of Ohio.

Date____________________ Signature of Board Secretary ____________________ **SEAL**

10. Why are you applying for reinstatement of your Ohio license?____________________

____

11. Have you been entitled to practice in each of the jurisdictions specified under question 6, continuously from the date you first became entitled until the present? If NO, why? ☐ Yes ☐ No

12. Have you been suspended from practice, reprimanded, censured, or otherwise disciplined or disqualified as a dentist or a member or any profession? 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) ☐ Yes ☐ No

13. A. Have you been convicted of or plead guilty to any felony or misdemeanor? (Exclude all traffic violations other than those involving driving while under the influence of alcohol or other drugs.)? If YES, attach statements giving dates and disposition. ☐ Yes ☐ No

B. Do you have any criminal charges pending against you? If YES, attach statement giving details of the matter and the name and address of the authority in possession of the record thereof. ☐ Yes ☐ No

14. 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? If YES, attach statements, giving full explanation, including name and address of doctor and institution. ☐ Yes ☐ No

15. Are you now, or have you ever been addicted to, or have received treatment for, the habitual use of narcotics or alcohol? If YES, attach statement giving full explanation, dates, places, etc.

☐ Yes
☐ No

16. Are you currently immune to, or have you received inoculation against the hepatitis B virus?

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.

☐ Yes
☐ No

Medical Report

17. I ____, a duly licensed physician in the State of ________________,

have this day examined ____________________________________, and my medical examination reveals that to the best
Name of Applicant
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 ____

18. Are there any unsatisfied judgements AGAINST you? If yes, list the details, giving amounts, dates and the nature of the judgement, and the reason for non-payment.

☐ Yes
☐ No

19. Give the name and locations of each dental association of which you have been a member during the PRECEDING five years. ____

AFFIDAVIT

20. STATE OF __________________________________)

SS.

COUNTY OF _______________________________)

I have carefully read the questions in the foregoing application and have answered them truthfully, fully and completely, without mental reservation of any kind.

I fully understand that failure to make a full disclosure of any fact or information called for may result in the denial of my application.

I hereby authorize all educational institutions, governmental agencies and instrumentalities, my references, employers and business and professional associates (past and present), to release to the Ohio State Dental Board any information, files or records requested by the Board in connection with the processing of this application.

I hereby WAIVE all provisions of law forbidding any physician or other person who has attended to or examined me, or who may hereafter attend to or examine me, from disclosing any knowledge or information which he/she thereby acquired, and I hereby consent that he/she may disclose such knowledge or information to the Ohio State Dental Board.

I hereby certify that I have read carefully and understand the law and rules pertaining to the practice of dentistry.

Being duly sworn, ____ says that he/she is the person referred to in this application and that the foregoing statements are true in every respect, and that the attached photograph is a true likeness of himself/herself taken within the last six (6) months.

Signature of Applicant ____

S E A L

Sworn to and subscribed before me this ______ day of _______________, _________

Signature of Notary ____

Certificates of Good Moral Character of Applicant (signed by two licensed dentists)

21. This certifies that I know ____to be of good moral character and recommend him/her to the Ohio State Dental Board as entirely worthy of a license to practice dentistry in the State of Ohio. I have known this applicant for _______ years.

SIGNATURE OF CERTIFYING DENTIST ____

DATE CERTIFIED ____

TYPE NAME OF DENTIST		ADDRESS	
GRADUATE FROM	DATE	LICENSE #	STATE OF ISSUANCE

22. This certifies that I know ____to be of good moral character and recommend him/her to the Ohio State Dental Board as entirely worthy of a license to practice dentistry in the State of Ohio. I have known this applicant for _______ years.

SIGNATURE OF CERTIFYING DENTIST ____

DATE CERTIFIED ____

TYPE NAME OF DENTIST		ADDRESS	
GRADUATE FROM	DATE	LICENSE #	STATE OF ISSUANCE

This space to be COMPLETED by the Ohio State Dental Board

Application	☐ Approved ☐ Disapproved	Date