



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 LICENSURE FOR GRADUATES OF UNACCREDITED DENTAL COLLEGES LOCATED OUTSIDE THE UNITED STATES

Thank you for your inquiry, indicating your interest in applying for a dental license in the State of Ohio. The following are prerequisites for receiving an application for a license:

- (1) A certified copy of your birth certificate.
- (2) Certification from the U.S. Immigration Service on residence status.
- (3) National Board "Final Report Card." Xerox copies of this card are not acceptable. The card becomes a part of your permanent record and will not be returned. The National Board Report Card is available for a nominal fee from the National Board, 211 East Chicago Avenue, Chicago, IL 60611, phone (312)440-2678.
- (4) Proof of having passed either the "Test of English as a Foreign Language" (TOEFL), with a score of 650; or attainment of level 109 in the "English Language Service Test." These examinations are available through American universities.
- (5) The following notarized credentials in English translation:
 - (a) Diploma or evidence of graduation from a dental school.
 - (b) Evidence of being licensed or admitted to practice in the country of graduation.
 - (c) Complete transcript of all academic grades in dental school with courses completed, along with pre-dental school transcripts.
- (6) The following information is required:
 - (a) An FBI identification record check. *See enclosed information.*
 - (b) A certification letter from each of the state boards of dental examiners where you hold or have held a dental license.
 - (c) Letters of recommendation from each of the local dental associations or societies of which you have been a member during the preceding five years.
- (7) **You must also send a certified attestation, acceptable to the Board, from the faculty of an accredited dental college, that you have had a laboratory examination, and clinical training in all phases of general dentistry, and that you presently possess clinical skills at least equal to the graduates of that school. (See enclosed form.)** Since the vast majority of American dental schools do not offer a laboratory examination, and the laboratory examinations that are offered may not be acceptable to the Ohio State Dental Board, it is recommended that the applicant enroll in a two-year program in an accredited dental school that includes clinical training and which is commensurate with the final two years of dental school.
- (8) Proof of immunity to or immunization against the hepatitis B virus.
- (9) ***After receipt and evaluation of the above-requested information, you will be notified if you are eligible to apply to take the North East Regional Board clinical examination, and receive a license in the State of Ohio.***

Prior to receiving an Ohio license you must pass a written jurisprudence examination on the Dental Practice Act, Chapter 4715. of the Ohio Revised Code. This examination is available on our homepage at www.dental.ohio.gov under Jurisprudence exams.

Enclosures



OHIO STATE DENTAL BOARD

APPLICATION FOR DENTAL LICENSURE FOR GRADUATES OF UNACCREDITED DENTAL COLLEGES LOCATED OUTSIDE THE UNITED STATES

THE APPLICATION MUST BE COMPLETE AND THE APPROPRIATE FEE SUBMITTED BEFORE LICENSURE WILL BE CONSIDERED. REMIT APPLICATION MATERIALS TO: OHIO STATE DENTAL BOARD, 77 SOUTH HIGH STREET, 18TH FLOOR, COLUMBUS, OHIO 43215-6135.

| | | | | | |
|---|-------------------|---------------|--|--|--------|
| 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> | |
| 4. DATE OF BIRTH | AGE | SEX | <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE | | |
| 5. SOCIAL SECURITY NO. | | | | | |
| 6. CITIZENSHIP: COUNTRY | | | | | |
| 7. PHYSICAL DESCRIPTION | COLOR OF HAIR | COLOR OF EYES | | | |
| BUILD | HEIGHT | WEIGHT | | | |
| MARKS | | | | | |
| 8. OHIO BOARD EXAMINATION GRADES: _____ | | | | | |
| NATIONAL BOARD REPORT CARD: <input type="checkbox"/> ENCLOSED <input type="checkbox"/> WILL BE SENT BY NATIONAL BOARD | | | | | |
| 9. 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 | TO |
| | | | | MO/YR | MO/YR |
| | | | | MO/YR | MO/YR |
| PRE DENTAL EDUCATION | | | | | |
| 10. COLLEGE/UNIV. ATTENDED | LOCATION | DEGREE | FROM MO/YR | TO MO/YR | |
| | | | | | |
| | | | | | |
| DENTAL EDUCATION | | | | | |
| 11. NAME OF SCHOOL | LOCATION | NO. OF YRS. | FROM MO/YR | TO MO/YR | DEGREE |
| | | | | | |
| | | | | | |
| | | | | | |

OTHER STATE LICENSES

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. 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/HYGIENIST, 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

NAME OF APPLICANT

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
 (NAME OF BOARD)
 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 RESIDENT'S/TEACHER'S 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, OTHER THAN NON-MOVING TRAFFIC VIOLATIONS 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 THERE ANY UNSATISFIED JUDGEMENTS AGAINST YOU? YES NO
 IF YES, LIST THE DETAILS, GIVING AMOUNTS, DATES, AND THE NATURE OF THE JUDGEMENT, AND THE REASON FOR NON-PAYMENT

23. GIVE THE NAME AND LOCATION OF EACH DENTAL ASSOCIATION OF WHICH YOU HAVE BEEN A MEMBER DURING THE PRECEDING FIVE YEARS:

24. ARE YOU A RESIDENT OF THE STATE OF OHIO? YES NO

25. 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.

AFFIDAVIT

26. STATE OF _____)
 COUNTY OF _____) **SS.**

BEING DULY SWORN, SAYS THAT HE IS THE PERSON REFERRED TO IN THIS APPLICATION AND THAT THE FOREGOING STATEMENTS ARE TRUE IN EVERY RESPECT, AND THAT THE ATTACHED PHOTOGRAPHS IS A TRUE LIKENESS OF HIMSELF TAKEN WITHIN THE LAST SIX MONTHS.

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 EDUCATION 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 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 HE THEREBY ACQUIRED, AND I HEREBY CONSENT THAT HE MAY DISCLOSE SUCH KNOWLEDGE OR INFORMATION TO THE OHIO STATE DENTAL BOARD.

I HEREBY CERTIFY THAT I HAVE READ CAREFULLY AND UNDERSTAND THE LAWS AND RULES PERTAINING TO THE PRACTICE OF DENTISTRY.

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 FOR LICENSURE

(TO BE SIGNED BY TWO DENTISTS)

27. THIS CERTIFIES THAT I KNOW _____ TO BE OF GOOD MORAL CHARACTER AND RECOMMEND HIM/HER TO THE OHIO STATE DENTAL BOARD.
 I HAVE KNOWN THIS APPLICANT FOR _____ YEARS.

PLEASE TYPE THE FOLLOWING INFORMATION:

| | | | | | |
|----------------------------|---------|-----|------|-----------|-------------------|
| TYPE NAME OF ABOVE DENTIST | ADDRESS | | | | |
| GRADUATE FROM | MONTH | DAY | YEAR | LICENSE # | STATE OF ISSUANCE |

28. THIS CERTIFIES THAT I KNOW _____ TO BE OF GOOD MORAL CHARACTER AND RECOMMEND HIM/HER TO THE OHIO STATE DENTAL BOARD.
 I HAVE KNOWN THIS APPLICANT FOR _____ YEARS.

| | | | | | |
|----------------------------|---------|-----|------|-----------|-------------------|
| TYPE NAME OF ABOVE DENTIST | ADDRESS | | | | |
| GRADUATE FROM | MONTH | DAY | YEAR | LICENSE # | STATE OF ISSUANCE |

THIS SPACE TO BE COMPLETED BY THE OHIO STATE DENTAL BOARD

| | | | |
|-------------|---|----------------|-------------|
| APPLICATION | <input type="checkbox"/> APPROVED <input type="checkbox"/> DISAPPROVED | LICENSE NUMBER | DATE ISSUED |
|-------------|---|----------------|-------------|

DATE OF OHIO BOARD EXAMINATION: _____
 PASSED FAILED

DATE OF OHIO JURISPRUDENCE EXAMINATION _____
 PASSED FAILED



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

I, _____, Dean of the
Name of Dean

_____, do hereby
Name of Institution

certify that _____, has passed
Name of Applicant

examinations in basic science, and a laboratory examination, consisting of

| SECTION | GRADE |
|---------|-------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

I further attest that _____ has had
Name of Applicant
clinical training, and is equivalent in competence to the graduates of this
institution.

Signature of Dean

Name of Institution

S E A L

Address

City State Zip Code