

**STATE OF NEW JERSEY
DEPARTMENT OF LAW AND PUBLIC SAFETY
DIVISION OF CONSUMER AFFAIRS
NEW JERSEY STATE BOARD OF DENTISTRY**

INSTRUCTIONS FOR REINSTATING A DENTIST LICENSE TO ACTIVE STATUS

1. Submit:

- a. A completed **application** for reinstatement.
- b. Your most recent **resume**, which includes your present employer.
- c. An **affidavit of employment** listing each job held during the lapsed licensure or certification period. This affidavit of employment must include the names, addresses and telephone numbers of each employer.
- d. A **notarized statement** indicating whether or not you were engaged in the practice of your profession or occupation in New Jersey during the period that your New Jersey license or certificate was lapsed. If you were practicing your profession or occupation during this lapsed license period, you must include a description of the type of work that you were involved with.
- e. Proof that you have completed **continuing education courses**, as required by **N.J.S.A.** 45:6-10.1 and **N.J.A.C.** 13:30-5.1. Acceptable proof would include, but not be limited to, a copy of your CPE certificates.
- f. Submit a completed **Certification and Authorization Form** for a criminal history background check.
- g. A **check or money order** payable to the NJ State Board of Dentistry. To determine the appropriate amount, please see the schedule of fees below. Please be advised that if your license is currently “Expired,” and you desire an “Active” license, you must pay the reinstatement fee **plus** all past delinquent renewal fees (see **N.J.A.C.** 13:30-8.6(e)(1)). If your license is currently in “Inactive-Unpaid,” or “Retired” status, you must pay only the reinstatement fee and the current renewal fee.

SCHEDULE OF FEES	
Reinstatement Fee	200.00
2001–2003 Renewal Fee	170.00
2003–2005 Renewal Fee	280.00
2005–2007 Renewal Fee	390.00
2007-2009 Renewal Fee	390.00
2009-2011 Renewal Fee	170.00
2011-2013 Current Renewal Fee	390.00

* A dentist seeking to reinstate a license or registration that has been “expired” for more than five years may be required to complete an examination to show evidence of current knowledge and skill in the practice of dentistry.

2. Mail to:

Attn: Reinstatements
New Jersey State Board of Dentistry
PO Box 45005
Newark, NJ 07101

NOTE: YOUR APPLICATION WILL NOT BE PROCESSED UNTIL THE BOARD HAS RECEIVED ALL OF THE REQUIRED DOCUMENTS NOTED ABOVE. FAILURE TO SUBMIT ALL OF THE REQUESTED DOCUMENTATION WILL DELAY THE PROCESSING OF YOUR APPLICATION. PLEASE BE ADVISED, THE BOARD MAY REQUEST THAT YOU SUBMIT ADDITIONAL INFORMATION IN ORDER TO PROCESS YOUR APPLICATION.

Application for Reinstatement - Dentist

This application must be completed, notarized and accompanied by the proper reinstatement fee in order for this form to be processed.

1. Personal Information *(Write name and address as it should appear on license.)*

First Name	Middle	Last Name
Street	City/State	Zip Code
Home Telephone	Office Telephone	Cell Phone
Date of Birth	Type of License/Certificate	NJ License/Certificate Number
Initial License/Certificate Date	Date of Last Renewal	

2. Social Security

Social Security No.:

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Pursuant to N.J.S.A. 2A:17-56.44e of the New Jersey child support enforcement law and N.J.S.A. 54:50-25 of the New Jersey taxation law, the Board or licensing agency to which this form is submitted is required to obtain your social security number and/or federal taxpayer identification number, and where neither is possessed, the reason for not having such a number. The Board is further obligated to provide these identifying numbers to the Director of Taxation and the other Probation Division or agency responsible for child support enforcement.

Voluntary Consent for Use of Social Security Number:

(Separate from uses mentioned in the above paragraph, a social security number may be used for these other purposes if consent is given.)

You are notified that under the Federal Privacy Act (5 U.S.C. Section 552a (note (b))), the Board or licensing agency to which this form is submitted is requesting the voluntary disclosure of your social security number. If you give your consent for the use of your social security number, it may be used: to verify the identity of an applicant, to aid in the collection of financial obligations due and owing the Board or any other state agency, and to aid in the disclosure to enforcement state or federal law and licensing officials and agencies of information obtained in investigations pertaining to licensure and disciplinary proceedings.

I, *(insert name)* _____, Consent Do Not Consent to the use of my social security number for any purposes set forth above. I understand that my consent is voluntary and that if I do not consent, no adverse action or inference will be taken or drawn.

3. Background Information

List all states in which you hold or have held a dental license. If you need more room, please use a separate piece of paper. *A letter of verification from each state licensing board must be received before your application can be considered.*

_____	_____	_____
_____	_____	_____

Please answer all questions from the time period that you were last licensed or certified in the state of New Jersey.

- a. Have you been convicted of a crime? Yes No
- b. Are there any criminal charges against you now pending?
(Parking or speeding violations do not require you to answer "Yes," but all other vehicle offenses must be disclosed.) Yes No
- c. Has your professional license been revoked or suspended (whether active or stayed) by any licensing board? Yes No
- d. Is any action now pending against your professional license or have you been permitted to surrender or otherwise relinquish your license to avoid inquiry, investigation or action by any state licensing board? Yes No

4. Continuing Education

Please list all courses that were successfully completed during the preceding registration period.

<u>Date</u>	<u>Title</u>	<u>Subject Matter</u>	<u>Sponsor</u>	<u>No. of Hours</u>
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5. Child Support Questions

In accordance with N.J.S.A. 2A:17-56.44d, an answer of "Yes" to any of the questions numbered 24 - 27 will result in a denial of licensure. Furthermore, any false certification may subject you to a penalty, including, but not limited to, immediate revocation or suspension of licensure.

- | | | |
|---|------------------------------|-----------------------------|
| a. Do you currently have a child-support obligation? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| If yes, please answer the following 2 questions: | | |
| 1. Are you in arrears in payment of that obligation? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 2. Does the arrears match or exceed the total amount payable for the past six months? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| b. Have you failed to provide any court-ordered health insurance coverage during the past six months? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| c. Have you failed to respond to a subpoena relating to either a paternity or child-support proceeding? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| d. Are you the subject of a child-support-related warrant? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

If you have answered "Yes" to any of these questions, please attach a written explanation to this application.

6. Certification

State of New Jersey, County of _____, _____
Name of Applicant

of _____
Address of Applicant

I have carefully read the questions in the foregoing application and have answered them completely without reservation, and I declare under penalty of perjury that my answers and all statements made by me therein are true and correct. Should I furnish any false information in this application, I hereby acknowledge that such act shall constitute cause for the denial, suspension or revocation of my license to practice dentistry in the State of New Jersey.

I realize that the foregoing information is necessary for an evaluation of my application, of which this is a part, and I fully recognize that full disclosure is essential to such procedures.

I have read the above and fully understand the contents.

Signature of Applicant

Sworn and subscribed to before me this _____ day

of _____, 20 _____

Signature of Notary Public



New Jersey State Board of Dentistry

Please print your name: _____

Date _____

Questions 1 through 9 pertain to medical conditions and use of chemical substances. If you answer "Yes" to question 1, you must answer questions 2 and 3. If you have answered "No" to question 1, continue with questions number 4 through 9. If you answer "Yes" to question 7, answer question 8. Please read the definitions below carefully. Your responses will be treated confidentially, and retained separately. Please be aware that you have a right to elect not to answer those portions of the following questions which inquire as to the illegal use of controlled dangerous substances or activity if you have reasonable cause to believe that answering may expose you to the possibility of criminal prosecution. In that event, you may assert the Fifth Amendment privilege against self-incrimination. Any claim of Fifth Amendment privilege must be made in good faith. If you choose to assert the Fifth Amendment, you must do so in writing to the Board office and confirm that by the answer given to questions number 5 and 9. You must fully respond to all other questions on the application. Your application for licensure will be processed if you claim the Fifth Amendment privilege against self-incrimination. You should be aware, however, that you may later be directed by the Attorney General to answer a question which you have refused to answer on the basis of the Fifth Amendment, provided that the Attorney General first grants you immunity afforded by statutory law (N.J.S.A. 45:1-20).

For the purposes of these questions, the following phrases or words have the following meanings:

"Ability to practice dentistry" is to be construed to include all of the following:

1. The cognitive capacity to make appropriate clinical diagnoses and exercise reasonable dental judgments and to learn to keep abreast of dental developments; and
2. The ability to communicate those judgments and dental information to patients and to other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
3. The physical capability to perform dental tasks such as dental examination and dental procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.

"Medical condition" includes physiological, mental or psychological conditions or disorders such as, but not limited to, orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction and alcoholism.

"Chemical substances" is to be construed to include alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

"Currently" does not mean on the day of, or even in the weeks or months preceding, the completion of this application. Rather, it means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, or within the past two (2) years.

"Illegal use of controlled dangerous substances" means the use of controlled dangerous substances obtained illegally (e.g. heroin or cocaine) as well as the use of controlled dangerous substances which are not obtained pursuant to a valid prescription or not taken in accordance with the directions of a licensed health care practitioner.

1. Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety? Yes No
2. If you answered "YES" to question 1, are the limitations or impairments caused by your medical condition reduced or ameliorated because you receive ongoing treatment (with or without medications) or participate in a monitoring program**? Yes No
3. If you answered "YES" to question 1, are the limitations or impairments caused by your medical condition reduced or ameliorated because of the field of practice, the setting or manner in which you have chosen to practice? Yes No
4. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism or voyeurism?
(See Question 5 for the Fifth Amendment option before responding.) Yes No
5. If you have chosen not to answer question 4 and instead have submitted a written Fifth Amendment assertion to the board office, check the "YES" box here. Yes No
6. Does your use of chemical substance(s) in any way impair or limit your ability to practice your profession with reasonable skill and safety? If this question does not apply, check "Not applicable" box. Yes No
If this question does not apply, check both the "No" box and the "Not Applicable" box. Not applicable
7. Are you currently engaged in the illegal use of controlled dangerous substances? (Recall that "currently" is defined as "within the last two years.")
See Question 9 for the Fifth Amendment option before responding. Yes No
8. If you answered "YES" to Question 7, are you currently participating in a supervised rehabilitation program or professional assistance program which monitors you in order to assure that you are not engaging in the illegal use of controlled dangerous substances? Yes No
9. If you have chosen not to answer question 7 above and instead have submitted a written Fifth Amendment assertion to the Board office, check the "YES" box here. Yes No

** If you receive such ongoing treatment or participate in such a monitoring program, the Board will make an individualized assessment of the nature, the severity and the duration of the risks associated with an ongoing medical condition so as to determine whether an unrestricted license should be issued, whether conditions should be imposed or whether you are not eligible for licensure.

"I certify that the information entered on this form is true and complete to the best of my knowledge, and further acknowledge that if the above information is willfully false, I am subject to punishment and/or disciplinary sanction including license suspension/revocation or the imposition of civil penalties as may be provided by law."

Signature of Licensee

Date

Print Name

Official Use Only

Dual License

License Type 1

Applicant's Number

License Type 2

Applicant's Number



New Jersey Office of the Attorney General

Division of Consumer Affairs

New Jersey State Board of Dentistry

P.O. Box 45005

Newark, New Jersey 07101

(973) 504-6405

Official Use Only

Resubmit

Board or Committee

**CERTIFICATION AND AUTHORIZATION FORM
FOR A CRIMINAL HISTORY BACKGROUND CHECK**

Directions: Answer all of the questions on this form.

1. Name Mr. _____ (_____)
 Mrs. _____ Last First Middle Maiden Name
 Ms.

2. Address _____
Street or P.O. Box City State ZIP code

3. Date of birth ____/____/____ Sex: Male Female
Month Day Year

4. Social Security number _____/_____/_____

5. Have you completed the fingerprinting process for any **Board or Committee of the New Jersey Division of Consumer Affairs** since November 2003? Yes No

If "No," you will receive a separate mailing from the Board or Committee regarding the criminal history background process. Please send no payment now.

If "Yes," please provide the following information and follow the instructions outlined below:

Board or committee requiring the fingerprinting Month and year you were fingerprinted

If you were fingerprinted after November 2003 as part of the criminal history background process for licensure or certification by any other any other **Board or Committee of the New Jersey Division of Consumer Affairs** (a background check conducted for the Department of Education, another state agency or another state does not apply) you will not be required to be fingerprinted a second time. However, the Division must perform a criminal history background check each time you apply for licensure or certification. **The fee for this service is \$25.30.** Payment should be made in the form of a check or money order payable to the State of New Jersey and should accompany your application packet.

6. Have you ever been arrested and/or convicted of a crime or offense? (Minor traffic offenses such as a parking or speeding violations need not be listed.) Yes No

Every such conviction on record must be disclosed. A true copy of every police report, judgment of conviction, sentencing order and termination of probation order, if applicable, **must** be submitted with this form. Any documents (including employer or supervisor letters of reference, if applicable) which present clear and convincing evidence of rehabilitation **must** be submitted with this form. **Failure to follow these instructions may result in the denial of an initial application.**

Note: Copies of judgments, sentencing and termination of probation orders may be obtained from the clerk of the county where those orders, disposing of the conviction, were issued and filed.

Your continuing responsibility to disclose convictions of crimes or offenses: You **must** notify the Board or Committee within five (5) business days if you are convicted of any crimes or offenses after this form has been completed.

Continuation on the reverse side ➡

CERTIFICATION

I, _____, in making this application to the Board or Committee for certification or licensure, certify that I am the applicant and that all of the information provided in connection with this application is true to the best of my knowledge and belief. I understand that any omissions, inaccuracies or failure to make full disclosures may be deemed sufficient to deny certification or licensure or to withhold renewal of or suspend or revoke a certificate or license issued by the Board or Committee.

I voluntarily consent to a thorough investigation of my present and past employment and other activities for the purpose of verifying my qualifications for certification or licensure. I further authorize all institutions, employers, agencies and all governmental agencies and instrumentalities (local, state, federal or foreign) to release any information, files or records requested by the Board or Committee.

I certify that the foregoing statements made by me are true. I am aware that if any of the foregoing statements made by me are willfully false, I am subject to punishment.

Signature of applicant

Date