# New Jersey State Board of Dentistry
# Resident Permit Application Checklist

Use this check-list to determine that you have complied with all of the requirements. Once your application is received, a file will be established and you will be notified if any documents are missing.

_____ Complete and return the Certification and Authorization Form For a Criminal History Background Check (CHBC), now required by law. The fee for this service is $78.00, which is to be paid directly to the vendor. Instructions will be provided in a follow-up letter.

_____ Enclose a $10.00 check or money order made payable to "State of New Jersey" and send with this application to: NJ Board of Dentistry, 124 Halsey Street, 6th Floor, P.O. Box 45005, Newark, NJ 07101

_____ Answer all questions on the application form.

_____ Write the complete school name and entire address of where you intend to do your residency.

_____ Enter your social security number.

_____ Have your dental school(s) provide an official school transcript in a sealed envelope. **DO NOT** open the envelope. Attach each sealed transcript(s) with the application, or arrange to have the school(s) forward the transcript(s) directly to the Board office. *(If you are applying prior to graduation, please note that your residency permit* ***cannot*** *be processed until your transcripts have been received. Have your school forward a copy of your transcripts directly to the Board office upon completion of your program.)*

_____ Have your official National Board scores (parts I and II) sent directly to the Board office:
NJ Board of Dentistry, 124 Halsey Street, 6th Floor, P.O. Box 45005, Newark, NJ 07101
***Please note: If you have successfully passed the NERB examination, you should apply for a dental license.***

_____ Use additional paper if you cannot fit all of your information in the space provided on this form. Make a notation by each question that more information has been attached. Please mark your attached answers with the same number corresponding to the question that you are answering.

_____ If you have answered 'yes' to any of the child support questions (25-28), please attach an explanation on a separate piece of paper to this application form.

_____ Fill out the Medical Conditions form (MC1) from your packet and send back with your application.

_____ Once the **entire** ***application*** has been completed, have it signed and stamped by a Notary Public.

**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. ☐ Ms. _____ ( _____ )
   Last First Middle Maiden Name

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 record background check process. No payment is necessary as of 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 **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 $17.50.** 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

**For Office Use Only**

Application No. _____

Check or Money Order _____

Process Date _____

License No. _____

# Application for Resident Permit

**(Please Print or Type)**

1. _____
First Name | Middle Name | Last Name | Maiden Name

2. _____
Home Address | City | State | Zip Code

3. _____ Male ☐ Female ☐
Place of Birth | Date of Birth | Age

4. ( ) _____ ☐ If unlisted, please check the box. _____
Telephone Number *(required)* | E-mail Address | Fax Number

5. Please print your name as it would appear on your license certificate.

_____

6. _____
Hospital program | City | State | Zip code

7. Dates of residency: From: _____ / _____ to _____ / _____

8. Are you a U.S. citizen? ☐ Yes ☐ No

If not, what is your immigration status with the Immigration and Naturalization Service?

_____

9. **Social Security Number** ☐☐☐ ☐☐ ☐☐☐☐

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 Probation Division or other 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 owning the Board or any other state agency, and to aid in the disclosure to state or federal law enforcement and licensing officials and agencies of information obtained in investigations pertaining to licensure and disciplinary proceedings

I, _____, ☐ 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.

## EDUCATION

10. Undergraduate Education _____ Year _____ Degree Obtained _____

11. Please list each dental school attended, using a separate sheet of paper if necessary
**ATTACH A SEALED OFFICIAL DENTAL SCHOOL TRANSCRIPT FROM EACH SCHOOL(S) LISTED BELOW.**

| Months and Years | Dental School | City, State, Country |
|---|---|---|
| ___ / ___ to ___ / ___ | _____ | _____ |
| ___ / ___ to ___ / ___ | _____ | _____ |

I received the degree of _____ on the _____ day of _____ , _____

12. **Other State Board Licenses** ____Yes ____No (If "No," proceed to question # 13.)

*(If your answer is "Yes," list all states in which you have or have had a license, including inactive or retired status. Attach a separate sheet of paper if necessary.)*

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| ___ | State _____ | Status _____ | | ___ | State _____ | Status _____ | |
| ___ | State _____ | Status _____ | | ___ | State _____ | Status _____ | |
| ___ | State _____ | Status _____ | | ___ | State _____ | Status _____ | |

## GENERAL QUESTIONS

**ALL QUESTIONS *MUST* BE ANSWERED. IF ANY ANSWER IS 'YES', PLEASE SUBMIT A COMPLETE AND ACCURATE EXPLANATION ON A SEPARATE PIECE OF PAPER AND ATTACH IT TO THE APPLICATION.**

13. Have you taken any State Board or Regional Board Examination(s) and failed? ☐ Yes ☐ No

**Examination History**

14. Please list the date each test was taken and passed:

a. National Boards Part I _____ Part II _____

b. N.E.R.B. _____ *(If you have taken and passed N.E.R.B., you may qualify for a license. Contact the Board office for information.)*

15. Has a licensing Board in any state or jurisdiction taken disciplinary action against you? ☐ Yes ☐ No

16. Has a licensing Board in any state or jurisdiction ever denied your application to practice dentistry or restricted your license in any way? ☐ Yes ☐ No

17. Have you ever been summoned; arrested; taken into custody; indicted; tried; charged with; admitted into pre-trial intervention (PTI); pled guilty to any violation of law, ordinance, felony, misdemeanor or disorderly persons offense; in this or any other state or in a foreign country? (Parking or speeding violations need not be disclosed, but motor vehicle violations such as driving while impaired or intoxicated must be.) ☐ Yes ☐ No

18. Have you ever been convicted of any crime or offense under any circumstances such as, but not limited to a plea of guilty, non vult, nolo contendere, no contest, etc., or a finding of guilt by a judge or jury? ☐ Yes ☐ No

19. Have you ever been a defendant in a malpractice suit? ☐ Yes ☐ No

20. Have you ever been denied malpractice insurance coverage? ☐ Yes ☐ No

21. Have you had any malpractice settlements or judgments entered against you in the past 10 years? ☐ Yes ☐ No
If 'yes', please explain and submit any documentation available.

22. Is there now, to your knowledge or belief, any action or investigation pending against you, by a regulatory agency, including but not limited to professional licensing agencies, Medicaid, Medicare, criminal authorities or any other government agency? ☐ Yes ☐ No

23. Do you hold a current DEA registration? ☐ Yes ☐ No

a. Has this registration ever been revoked or restricted? ☐ Yes ☐ No

24. List, in chronological order, employment, residencies or postgraduate training since your graduation from dental school (Please account for all years since graduation including addresses and dates. Use additional sheets if necessary.)

_____

_____

_____

_____

## CHILD SUPPORT QUESTIONS

In accordance with N.J.S.A. 2A:17-56.44d, an answer of "Yes" to any of the questions numbered 25 - 28 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.

25. Do you currently have a child-support obligation? If yes, ☐ Yes ☐ No

a. Are you in arrears in payment of that obligation? ☐ Yes ☐ No

b. Does the arrears match or exceed the total amount payable for the past six months? ☐ Yes ☐ No

26. Have you failed to provide any court-ordered health insurance coverage during the past six months? ☐ Yes ☐ No

27. Have you failed to respond to a subpoena relating to either a paternity or child-support proceeding? ☐ Yes ☐ No

28. Are you the subject of a child-support-related warrant? ☐ Yes ☐ No

**IF YOU HAVE ANSWERED 'YES' TO ANY OF THESE QUESTIONS, PLEASE ATTACH AN EXPLANATION TO THIS APPLICATION.**

License No.: _____ Form MC1

*For office use only*

# 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 incude all of the following:

1. The cognitive capacity to make appropriate clinical diagnoses and exercise reasonable dental judgements 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? Yes ☐ No ☐
(See Question 5 for the Fifth Amendment option before responding.)

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? 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.") Yes ☐ No ☐
See Question 9 for the Fifth Amendment option before responding.

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

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

of _____
Address of applicant

**Waiver**

I hereby authorize all hospitals or institutions (relating to residency or postgraduate programs attended therein) or organizations, my references, employers (past and present), business and professional associations (past and present), and all governmental agencies and instrumentalities (local, state, Federal or foreign) to release to the New Jersey State Board of Dentistry any information, files or records requested by the Board in connection with the processing of this application. I further authorize the New Jersey State Board of Dentistry to release to the organizations, individuals and groups listed above information which is material to my application.

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 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_____

_____
Notary Public

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**DO NOT WRITE IN THIS SPACE**

Date Received _____

Permit Number _____

National Board
Certification Date _____

N.E.R.B.
Certification Date _____

_____
Kevin B. Earle, Executive Director