

New Jersey State Board of Dentistry

Residency 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.

Upon approval of your application you will be notified by letter and requested to provide your initial license fees.

_____ Complete and return the Certification and Authorization Form For a Criminal History Background Check (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, P.O. Box 45005, 124 Halsey Street, 6th Floor, 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 at NJ Board of Dentistry, 124 Halsey Street, 6th floor, P.O. Box 45005, Newark, NJ 07101

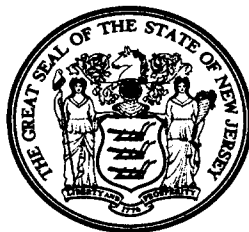
_____ Please have your official National Board or other clinical examination scores sent directly to the Board office at NJ Board of Dentistry, P.O. Box 45005, 124 Halsey Street, 6th Floor, Newark NJ 07101

_____ 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.



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. _____
 Place of Birth Date of Birth Age Male Female

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 owing 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; convicted or 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 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? If 'yes', please explain and submit any documentation available. Yes No
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.)
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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.

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.

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.

ÒMedical conditionÓ 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.

ÒChemical substancesÓ 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.

ÒCurrentlyÓ 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.

ÒIllegal use of controlled dangerous substancesÓ 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? 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



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 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_____

Notary Public

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

AFFIDAVIT

This affidavit is to be executed by the applicant before a notary public:

State of: _____
County of: _____ } ss.

I, _____, in making this application to the Board or Committee for certification or licensure, swear (or affirm) that I am the applicant and that all 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.

Signature of applicant

Sworn and subscribed to before me this _____

day of _____, _____
Month Year

Name of Notary Public (please print)

Signature of Notary Public

