IDAHO STATE BOARD OF DENTISTRY

♦PO BOX 83720 BOISE, ID 83720-0021 ♦PHONE: (208) 334-2369 ♦FAX: (208) 334-3247
♦WEBSITE: www.isbd.idaho.gov ♦EMAIL: sbdinfo@isbd.idaho.gov

VOLUNTEER DENTAL OR DENTAL HYGIENE LICENSE

Upon application and qualification, the board may issue, without examination, a volunteer's license to a dentist or dental hygienist who is retired from the active practice of dentistry or dental hygiene to enable the retired dentist or dental hygienist to provide dental or dental hygiene services at specified locations to persons who, due to age, infirmity, indigence or disability, are unable to receive regular dental treatment. A dentist or dental hygienist previously holding a dental or dental hygiene license with active status in Idaho or another state shall be considered to be retired if, prior to the date of application for a volunteer's license, he has surrendered or allowed his license with active status to expire with the intention of ceasing to actively practice as a dentist or dental hygienist for remuneration, he has converted his license with active status to a license with inactive status with the intention of ceasing to actively practice as a dentist or dental hygienist for remuneration, or he has converted his license with active or inactive status to a license with retirement or similar status that proscribed the active practice of dentistry or dental hygiene. A dentist or dental hygienist, whose dental or dental hygiene license had been restricted, suspended, revoked, surrendered, resigned, converted, or allowed to lapse or expire as the result of disciplinary action or in lieu of disciplinary action being taken shall not be eligible for a volunteer's license.

CHECKLIST

	Completed Application Mail to: ISBD, PO Box 83720, Boise, ID 83720-0021 Express Mail: 350 N 9TH Street, Suite M100, Boise, ID 83702
	Copy of Current CPR Certification
	License Verification Form (Included with Application Materials) License Verification Forms must be received directly from every state an applicant has held a license.

Important Information

- The specified locations at which a dentist or dental hygienist holding a volunteer's license may provide dental or dental hygiene services shall be limited to the premises or sites of extended access oral health care programs. The dental services provided at an extended access oral health care program by a dentist holding a volunteer's license shall not require or include the administration of general anesthesia or conscious sedation to a patient unless otherwise specifically approved in advance by the board.
- "Extended access oral health care program" means and includes: (a) Dental and dental hygiene treatment and services provided as part of a program conducted by or through a school district, county, state or federal agency, hospital, long-term care facility, public health district, dental or dental hygiene school, tribal clinic, or federally qualified health center; or (b) Oral health care programs approved by the board and conducted by or through a nonprofit public or private entity, organized in accordance with section 501(c)(3) or 501(c)(4) of the federal Internal Revenue Code, that provide free dental or dental hygiene services to persons who, due to age, infirmity, indigence, disability or other similar reason, may be unable to receive regular dental and dental hygiene treatment
- A volunteer's license shall be valid for that period specified for dentists and dental hygienists in section 54-920, Idaho Code, and may be renewed upon application of the licensee unless the license has been revoked in accordance with this section. The board shall maintain a register of all dentists and dental hygienists who hold a volunteer's license. The board shall not charge an application or licensing fee for issuing or renewing a volunteer's license. A volunteer's license cannot be converted to a license with active, inactive, provisional or special status.
- When practicing dentistry or dental hygiene within the permissible scope of a volunteer's license, the holder of a volunteer's license issued pursuant to this section shall be immune from liability for any civil action arising out of the provision of volunteer dental or dental hygiene services. This section does not provide or extend immunity to a holder of a volunteer's license for any acts or omissions constituting negligence.

Idaho State Board of Dentistry
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Web www.isbd.idaho.gov ♦ Email sbdinfo@isbd.idaho.gov

Application for a Volunteer's Dental or Dental Hygiene License

Personal Information		
Full Name (First, Middle, Last, Suffix):		
Maiden Name or Other Names Used:	SSN:	
Mailing Address:		
City:	State:	Zip:
Email Address:	Phone #:	
Date of Birth:	ID Dental/Dental Hygiene License Number:	

Verification of Dental or Dental Hygiene School Graduation	
Name and Location of Dental/Dental Hygiene School:	
Dates Attended (From MM/YY to MM/YY):	
Date of Graduation (Month and Year):	Degree Awarded:

State Licensure

List every state in which you are or have been licensed as a Dentist or Dental Hygienist.

State	License #	Status

DEA Number (If Applicable):	**State Issued Controlled Substance Registration Number(s) (If Applicable – Please Specify Which State):**

APPLICANT NAME: _____

PERSONAL DATA QUESTIONS	YES	NO
1. Were you ever expelled, requested to withdraw, reprimanded or placed on probation while attending any dental/dental hygiene school/program?		
2. Have you ever been refused or denied the privilege of taking any examination required for professional licensure?		
3. Have you ever been dismissed from any professional licensure examination due to improper behavior or unethical conduct?		
NOTE: IF YOU ANSWERED "YES" TO QUESTIONS (1), (2), OR (3), YOU MUST ATTACH A SIGNED WRITTEN STATEMENT PROVIDING A COMPLETE EXPLANATION OF THE EVENT OR CIRCUMSTANCES.		
4. Have you ever been denied a license to practice dentistry/dental hygiene or any other profession or occupation?		
5. Have you ever voluntarily surrendered a license to practice dentistry/dental hygiene and/or have you ever agreed to voluntarily restrict or limit your practice of dentistry/dental hygiene?		
6. If you answered "YES" to QUESTION (5), was disciplinary action pending against you, were you under investigation by a licensing agency at that time or, did you surrender or agree to restrict or limit your practice of dentistry/dental hygiene in lieu of disciplinary action being taken against you? ☐ N/A		
7. Have you ever been the subject of any proceeding by a licensing authority which either sought or resulted in censure, reprimand, probation, suspension, surrender, revocation, fine or other discipline/penalty in connection with any dental/dental hygiene or other professional license you held?		
8. Are charges or an investigation currently pending in connection with your dental/dental hygiene license in any other state?		
9. Have your clinical privileges or procedures ever been restricted by any hospital, outpatient clinic, or surgery center?		
10. Have you ever had a registration issued by a controlled substance authority revoked, suspended, surrendered, limited or restricted?		
11. Have you ever voluntarily surrendered a registration issued by a controlled substance authority?		
12. Are any professional liability or malpractice claims or complaints currently in process/pending against you?		
13. Have any settlement agreements been entered into or have any judgments been entered against you resulting from your practice of dentistry/dental hygiene?		
14. Have any judgments or settlements been paid on your behalf as a result of a professional liability or malpractice case(s)?		
15. Have you ever been denied participation in, or suspended from the Medicaid or Medicare benefit program?		
NOTE: FOR EACH "YES" ANSWER TO ANY QUESTIONS 4 – 15, YOU MUST ATTACH A SIGNED WRITTEN EXPLANATION AND PROVIDE COPIES OF ALL JUDGMENTS, DECISIONS, AND/OR AGREEMENTS.		
16. Are you currently or have you ever been licensed in any other state in any health care profession aside from dentistry/dental hygiene?		
17. Have you ever been discharged other than honorable from the armed service or from a city, county, state, or federal position?		
18. Do you currently have a child-support obligation?		
19. If yes, are you in arrears? ☐ N/A		
20. If yes, does the arrearage match or exceed the total amount payable for the past six months? ☐N/A		
NOTE: IF YOU ANSWERED "YES" TO QUESTIONS (16), (17), (18), (19), OR (20), YOU MUST ATTACH A SIGNED WRITTEN STATEMENT PROVIDING A COMPLETE EXPLANATION AND ATTACH ANY SUPPORTING DOCUMENTATION.		

APPLICANT NAME: _____

PERSONAL DATA QUESTIONS CONTINUED	YES	NO
21. Have you had or do you currently have a medical condition that in any way impairs or limits your ability to currently practice dentistry/dental hygiene safely and competently?		
22. Have you ever engaged in the improper use of drugs or other chemical substances?		
23. Have you used or do you currently use alcohol, drugs, or other chemical substances in a manner that would in any way impair or limit your ability to safely and competently practice dentistry/dental hygiene?		

NOTE:

"Ability to practice dentistry/dental hygiene safely and competently" means ALL of the following:
1. The cognitive capacity to make reasoned clinical judgments, and to learn and keep abreast of clinical developments;
2. The ability to communicate clinical judgments and information to patients and other health care providers; and
3. The capability to perform clinical tasks such as dental/dental hygiene examinations and dental/dental hygiene procedures.

"Medical condition" means any physiological or psychological condition, impairment, or disorder, including drug addiction and alcoholism.

"Drugs or chemical substances" mean alcohol, controlled substances, prescription drugs, illegal drugs, over-the-counter medications, nitrous oxide, petroleum products, adhesive products and other chemical substances taken for mood alteration.

"Improper use of drugs or other chemical substances" means ANY of the following:
1. The use of any controlled substance and/or prescription drug in an addictive manner and/or for any purpose and to any extent other than as directed by a licensed health care practitioner;
2. The use of any over-the-counter medication in an addictive manner and/or in a manner prohibited by law;
3. The use of alcohol in an addictive manner and/or to the extent that the use of alcohol impairs a person's ability to safely and competently practice as a dentist;
4. The manufacture, possession, distribution or use of any drug, medication or chemical substance in a manner prohibited by law.

24. If you answered "YES" to any questions 21 - 23, have you participated in any program or received treatment or are you currently participating in any program or receiving treatment that reduces or eliminates the limitations or impairments caused by either your medical condition or improper use of alcohol, drugs, or other chemical substances? ☐ N/A		
25. If you answered "YES" to any questions 21-23, does your field of practice, the setting, or the manner in which you practice dentistry/dental hygiene, reduce or eliminate the limitations or impairments caused by either your medical condition or improper use of alcohol, drugs, or other chemical substances? ☐ N/A		

NOTE: IF YOU ANSWERED "YES" TO ANY QUESTIONS 21 - 25, YOU MUST ATTACH A SIGNED WRITTENT STATEMENT ATTESTING THAT YOU ARE PHYSICALLY AND MENTALLY ABLE TO PERFORM THE FUNCTIONS OF THE LICENSE YOU SEEK AND THAT THERE ARE NO MEDICAL CONSIDERATIONS IN YOUR HEALTH HISTORY THAT MAY POSE A THREAT TO THE PATIENTS YOU TREAT AND ATTACH ANY DOCUMENTATION INCLUDING COPIES OF EVALUATIONS AND RECOMMENDATIONS FOR TREATMENT IF ANY WERE ISSUED.

PERSONAL DATA QUESTIONS CONTINUED	YES	NO
26. Have you ever been arrested, charged, cited, indicted, found guilty of, or entered a plea of guilty or no contest to a felony or misdemeanor crime or offense, including actions that resulted in a deferred or expunged judgment?		
27. Have you ever received a withheld judgment or suspended sentence for any felony or misdemeanor in a criminal proceeding?		
28. Do you have any felony or misdemeanor criminal charges currently pending against you in any state or country?		
29. Are you currently charged with or have you been convicted of a criminal act that requires registration under the Sex Offender Registration Act?		
NOTE: IF YOU ANSWERED "YES" TO ANY QUESTION 26 – 29, YOU MUST SEND DOCUMENTATION SUCH AS CERTIFIED COPIES OF ALL COURT DOCUMENTS RELATED TO YOUR CRIMINAL HISTORY. DOCUMENTATION MAY INCLUDE COPY OF CRIMINAL CHARGES, REPORTED OFFENSE, POLICE REPORT, JUDGMENT AND DISPOSITION, FINAL DISPOSITION, AND ANY ORDERS OR ANY ACTIONS PENDING. BE SURE TO INCLUDE THE JURISDICTION THAT IS INVESTIGATING AND/OR PROSECUTING THE CHARGES. THIS INCLUDES ANY CITY, COUNTY, STATE, FEDERAL, OR TRIBAL JURISDICTION.		

Affidavit of Applicant and Authorization for Release of Personal Information

I, the undersigned, hereby state and attest that I am the person identified in this application and that I am making application to the Idaho State Board of Dentistry for a volunteer's dental/dental hygiene license. I further state and attest that I have thoroughly read and answered the questions in this application and that the information I provided was true, correct and complete to the best of my knowledge and belief. I understand that furnishing false information in connection with this application shall constitute grounds for the denial of my application.

I understand and acknowledge that there are limitations in connection with practicing dentistry/dental hygiene in Idaho under the authority of a volunteer's license. I specifically understand and agree that I can only provide volunteer dental/dental hygiene treatment in extended access oral health care programs and that I cannot accept remuneration for the treatment I provide, except for reimbursement to the extent of actual expenses I incur as a volunteer dentist/dental hygienist. I also understand and agree that I am precluded from providing treatment to any patient who has been sedated to the level of conscious sedation or general anesthesia/deep sedation unless prior authorization is obtained from the Board of Dentistry.

By my signature on this application, I hereby authorize third parties/entities including, but not limited to, dental/dental hygiene schools and licensing authorities to release any information or records requested by the Board of Dentistry in connection with this application. I further authorize the Board of Dentistry to release information and records obtained in connection with my application to the above-mentioned third parties/entities to the extent necessary to assist in the determination of my qualifications for a volunteer's dental/dental hygiene license. I acknowledge that the records in the custody and control of the Board of Dentistry are subject to public disclosure to the extent of and in the manner specified in the Idaho Public Records Act.

Signature of Applicant _____

Subscribed and Sworn to before me this _____ day of _____, _____

Signature of Notary Public _____

Notary Public for _____ My commission expires: _____

SEAL

CERTIFICATION OF LICENSURE

As part of the license application process, the Idaho State Board of Dentistry requires that this form be completed by every board that has ever issued any license to the applicant, even if the license is not current. The completed form must be mailed directly from the state licensing board to the **Idaho State Board of Dentistry.** Any processing fees are the applicant's responsibility. The applicant's signature authorizes release of information, favorable or otherwise, directly to the Board.

Print Name _____ **License #**_____

Signature _____ **Date** _____

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This portion of the form should be completed by the state licensing board.

IT IS HEREBY CERTIFIED THAT _____
(Name of Applicant)

WAS GRANTED LICENSE NUMBER_____ **DATE ISSUED**_____

TO PRACTICE_____ **IN THE STATE OF**_____

DATE LICENSE EXPIRES_____ **LICENSE STATUS**_____

BASIS FOR LICENSURE:

- ☐ **Endorsement/Credentials**
- ☐ **State Board Prepared Written and/or Clinical Exam**
- ☐ **Regional Clinical Exam, Name of Testing Agency** _____

☐ **YES** ☐ **NO** **Disciplinary action ever been initiated, pending, or taken? (If yes, please provide contact information to obtain further information regarding disciplinary action.)**

STATE LICENSING BOARD OFFICIAL:

Print Name _____ **Title** _____

Signature _____ **Date**_____

Phone #_____ **Fax #**_____

Return completed form to:

IDAHO STATE BOARD OF DENTISTRY
PO Box 83720
Boise, ID 83720-0021
Phone (208) 334-2369

State or Board Seal