Dental Quality Assurance Commission
P.O. Box 47877
Olympia, WA 98504-7877
360.236.4700

Dentistry via Examination License Application Packet

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Important Social Security Number Information:

Social Security Number: You are required by state and federal law to provide a social security number with your application. If you do not have a social security number at the time you send in this application, contact the Customer Service Center at 360.236.4700 for more information.

A U.S. Individual Taxpayer Identification Number (ITIN) or a Canadian Social Insurance Number (SIN) cannot be substituted.

In order to process your request:

Mail your application with Initial documentation and your check or money order payable to:

Department of Health
PO Box 1099
Olympia, WA 98507-1099

Send other documents not sent with initial application to:

Dental Quality Assurance Commission
PO Box 47877
Olympia, WA 98504-7877

Contact us:

360.236.4700

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Application Instructions Checklist

Use this application to get a dental license if you have completed one of the following examinations within the five years immediately preceding application.

- Western Regional Examining Board (WREB), accepted since 1994.
- Central Regional Dental Testing Service (CRDTS), accepted since 2001.
- Southern Regional Testing Agency (SRTA), accepted since 2006.
- East Regional Examining Board (NERB), accepted since 2006.

Note: Foreign trained dentists must meet the specific education requirements for Washington State. Refer to WAC 246-817-160.

Important background check Information: Washington State law authorizes the Department of Health to obtain fingerprint-based background checks for licensing purposes. This check may be through the Washington State Patrol and the Federal Bureau of Investigation (FBI). This may be required if you have lived in another state or if you have a criminal record in Washington State. This would be at your own expense.

All information should be typed or printed clearly. It is your responsibility to submit the required forms required.

☐ **Application Fee**. This fee is non-refundable. You can check the **fee page** for current fees.

☐ **#1: Demographic Information:**
Social Security Number: You must list your social security number on your application. Please call the Customer Service Center at 360.236.4700 if you do not have one.

Legal Name: List your full name.

Definition of legal name: “Legal name” is the name appearing on your official certificate of birth or, if your name has changed since birth, on an official marriage certificate or an order by a court. The court must have the legal authority to change your name. We may ask you to prove your legal name. If you use any name other than your legal name on this form, your application may be denied.

Birth date: Provide the city, state and country where you were born.

Address: List the address we should use to send any information on your license. Be sure to include the city, state, zip code, county, and country. This will be your permanent address with the Department of Health until we have been notified of a change.
See **WAC 246-12-310**.

Phone, Fax and Cell Numbers: Enter your phone, fax and cell numbers, if you have them.

Email: Enter your email address, if you have one.

Other Name(s): Indicate whether you are known or have been known under any other names. If you have a name change, you must notify the Department of Health in writing. You must include proof of this change. See **WAC 246-12-300**.

- [ ] **#2: Personal Data Questions:**
All applicants must answer the same personal data questions. They are focused on your fitness to practice the essential skills of this profession.

If you answer "yes" to any questions in this section, you must provide an appropriate explanation. You must also provide the documentation listed in the note after the question. If you do not provide this, your application is incomplete and it will not be considered.

- Question 5 includes misdemeanors, gross misdemeanors and felonies. You do not have to answer yes if you have been cited for traffic infractions. You can get copies of court records through the county courthouse where the conviction, plea, deferred sentence, or suspended sentence was entered.
- Another jurisdiction means any other country, state, federal territory, or military authority.

- [ ] **#3: Professional Training and Experience:**
Please list in date order all professional work experience. Include all periods of time from the date of graduation from dental school to present whether or not engaged in activities related to dentistry. If you need more space, attach a piece of paper.

- [ ] **#4: Previous License:**
List all states where licenses are or were held. Specifically list licenses granted as temporary, reciprocity, exemption or similar with type, date, grantor, and if license is current. If you need more space, attach a piece of paper.

- [ ] **#5: AIDS Education and Training Attestation:**
AIDS affidavit must be initialed and dated. AIDS training may include self-study, direct patient care, courses, or formal training required by **WAC 246-12-260**. Course content can be found in **WAC 246-12-270**.

- [ ] **#6: Applicant's Photograph:**
Attach a current photograph in the box provided or attach it to the application. Indicate date the photograph was taken and sign in ink across the bottom of the photo. The photograph must be a clear, close up and a front view. Your application will not be processed without a current photograph.

- [ ] **#7: Applicant's Attestation:**
You must sign and date this for us to process the application. Make sure you understand this section. Application must be notarized.

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License Requirements

Thank you for applying to become a licensed dentist in Washington State. To expedite the license process, ensure the following information has been included with your application.

☐ **National Board Scores (Part I and II)**

The original scorecard or a notarized copy of the scores must be provided. To get documentation contact:
Joint Commission on National Dental Examinations
211 East Chicago Avenue, Suite 1846
Chicago, Illinois 60611
1.800.621.8099

☐ **Disclosure of Information Authorization**
To be completed by persons currently licensed in other jurisdictions. This authorization allows us to conduct background checks from the listed entities. (Form enclosed)

☐ **DEA**
Complete this form if you have ever had a DEA number and submit it directly to the Drug Enforcement Administration in Seattle. To contact the Seattle DEA, call 1.888.219.1418. (Form enslosed)

☐ **Exam Scores**
A notarized copy of the original Examination Board's (WREB, CRDTS, SRTA, NERB) certificate must be sent. This document verifies passage of the examination, date and location taken, and confirms that no outstanding requirements are owed. Examination results will be accepted for up to five years preceding application to Washington State. Applications for the examination should be requested directly from one of the following:

- WREB at 602.944.3315
- CRDTS at 785.273.0380
- SRTA at 757.428.1003
- NERB at 301.563.3300 ext. 227.

☐ **Jurisprudence Examination**
Complete the on-line examination **http://www.doh.wa.gov/hsqa/Professions/Dental/E_Exam/Dental_Exam.htm**. Print and send your certificate of completion with your application. It is a multiple choice exam and designed to familiarize you with the Washington State dentistry laws. Current laws can be found at **http://www.doh.wa.gov/hsqa/Professions/Dental/laws.htm**.

The following require you to verify the primary source, they will only be accepted when mailed directly to the department from the source. These items should not be included with your application. They should be sent to the address above.

☐ **Transcript (with degree posted)**
Transcripts must be posted with dental degree from an accredited dental school and include the date of graduation. Non-posted transcripts or student copies are not acceptable. Foreign trained dentists must meet the additional education requirements outlined in **WAC 246-817-160**.

- [ ] **License Verifications**
License verifications must be requested by the applicant and submitted directly from every state.

Note: Many states charge a verification processing fee. Contact them prior to request to prevent delays in processing.

- [ ] **Malpractice Clearance**
Applicants must have malpractice carriers submit a letter verifying dates of coverage and any claims history. In the event of a claims history, appropriate legal documentation must also be submitted. If coverage is provided via an umbrella policy through a school, or if you are practicing in the military, please indicate in writing.

- [ ] **Military/Commanding Officer Letter**
If applicant is on active duty in the military, a letter must be submitted from the commanding officer outlining duties, length of service and whether any adverse actions have been reported or taken.

You will be notified in writing if further documentation is required. Please do not call to check on the status of an application. This will allow program staff to prepare your file for reactivation

- The application is considered incomplete if requested information is left blank. State N/A or place a line through section instead of leaving blank.
- The initial license will expire on your birthday unless the license is issued within 90 days of your next birthday. See WAC 246-12-020 (3).
- You will receive a courtesy renewal notice if your address of record is kept up to date. Any renewal postmarked or presented to the department after midnight on the expiration date is late.

Note: You cannot practice dentistry until your license is issued.

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Background Check Stamp Here	Date Stamp Here

Rev 0251030000

Dentist Practice License Application by Exam

Please type or print clearly. It is the responsibility of the applicant to submit or request all required supporting documents be submitted. Failure to do so could result in a delay in processing your application. Make sure you read the instructions.

1. Demographic Information

Social Security Number (If you do not have a social security number, see instructions.)
— —

☐ Male
☐ Female

Name	First	Middle	Last

Birth date (mm/dd/yyyy)	Place of birth		
	City	State	Country

Address

City	State	Zip	County

Country

Phone ( )	Fax ( )	Cell ( )

Email address

Mailing address (if different from above)

City	State	Zip	County

Country

NOTE: The mailing and email addresses you provide will be your addresses of record. It is your responsibility to maintain current contact information with the department.

Have you ever been known under any other name(s)? ☐ Yes ☐ No If yes, list name(s):

Will documents be received in another name? ☐ Yes ☐ No

If yes, list name(s): ______________________________

Dental school	Year graduated

DEA # (if applicable)

For Office Use Only

Certificate # ______________________ Issue Date ______________________

Validation Date ______________________ Received ______________________

2. Personal Data Questions

Yes No

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? If yes, please attach explanation. ☐ ☐

   "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.

   If you answered yes to question 1, explain:

   1a. How your treatment has reduced or eliminated the limitations caused by your medical condition.

   1b. How your field of practice, the setting or manner of practice has reduced or eliminated the limitations caused by your medical condition.

   Note: If you answered "yes" to question 1, the licensing authority will assess the nature, severity, and the duration of the risks associated with the ongoing medical condition and the ongoing treatment to determine whether your license should be restricted, conditions imposed, or no license issued.

   The licensing authority may require you to undergo one or more mental, physical or psychological examination(s). This would be at your own expense. By submitting this application, you give consent to such an examination(s). You also agree the examination report(s) may be provided to the licensing authority. You waive all claims based on confidentiality or privileged communication. If you do not submit to a required examination(s) or provide the report(s) to the licensing authority, your application may be denied.

2. Do you currently use chemical substance(s) in any way which impair or limit your ability to practice your profession with reasonable skill and safety? If yes, please explain. ☐ ☐

   "Currently" means within the past two years.

   "Chemical substances" include alcohol, drugs, or medications, whether taken legally or illegally.

3. Have you ever been diagnosed with, or treated for, pedophilia, exhibitionism, voyeurism or frotteurism? ☐ ☐

4. Are you currently engaged in the illegal use of controlled substances? ☐ ☐

   "Currently" means within the past two years.

   Illegal use of controlled substances is the use of controlled substances (e.g., heroin, cocaine) not obtained legally or taken according to the directions of a licensed health care practitioner.

   Note: If you answer "yes" to any of the remaining questions, provide an explanation and certified copies of all judgments, decisions, orders, agreements and surrenders. The department does criminal background checks on all applicants.

5. Have you **ever** been convicted, entered a plea of guilty, no contest, or a similar plea, or had prosecution or a sentence deferred or suspended as an adult or juvenile in any state or jurisdiction? ☐ ☐

   Note: If you answered "yes" to question 5, you must send certified copies of all court documents related to your criminal history with your application. If you do not provide the documents, your application is incomplete and will not be considered.

   To protect the public, the department considers criminal history. A criminal history may not automatically bar you from obtaining a credential. However, failure to report criminal history may result in extra cost to you and the application may be delayed or denied.

2. Personal Data Questions (cont.)

Yes No

a. Are you now subject to criminal prosecution or pending charges of a crime in any state or jurisdiction ☐ ☐

Note: If you answered “yes” to question 5a, you must explain the nature of the prosecution and/or charge(s). You must include the jurisdiction that is investigating and/or prosecuting the charges. This includes any city, county, state, federal or tribal jurisdiction. If charging documents have been filed with a court, you must provide certified copies of those documents. If you do not provide the documents, your application is incomplete and will not be considered.

b. If you answered “yes” to question 5a, do you wish to have decision on your application delayed until the prosecution and any appeals are complete? ☐ ☐

6. Have you ever been found in any civil, administrative or criminal proceeding to have:
   a. Possessed, used, prescribed for use, or distributed controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes? ☐ ☐
   b. Diverted controlled substances or legend drugs? ☐ ☐
   c. Violated any drug law? ☐ ☐
   d. Prescribed controlled substances for yourself? ☐ ☐

7. Have you ever been found in any proceeding to have violated any state or federal law or rule regulating the practice of a health care profession? If “yes”, please attach an explanation and provide copies of all judgments, decisions, and agreements? ☐ ☐

8. Have you ever had any license, certificate, registration or other privilege to practice a health care profession denied, revoked, suspended, or restricted by a state, federal, or foreign authority? ☐ ☐

9. Have you ever surrendered a credential like those listed in number 8, in connection with or to avoid action by a state, federal, or foreign authority? ☐ ☐

10. Have you ever been named in any civil suit or suffered any civil judgment for incompetence, negligence, or malpractice in connection with the practice of a health care profession? ☐ ☐

3. Professional Training and Experience

List in chronological order all professional education and experience including college or university pre-dental program, technical or professional school and practice pertaining to the profession for which you are making application. Include all periods of time from the date of graduation from dental school to present whether or not engaged in activities related to dentistry. You do not have to list continuing education courses. If you need more space, attach a piece of paper.

Dates		Name and address of institute, place of practice.	Degree/certificate and date received Nature of experience or specialty
From (mm/dd/yyyy)	To (mm/dd/yyyy)		

4. Previous License

List all states where licenses are or were held. Please list all active, inactive and expired licenses. Previous credential to include license, certification or registration. Specifically list licenses granted as temporary, reciprocity, exemption or similar with type, date, grantor, and if license is current. If you need more space, attach a piece of paper.

State	Profession	Certificate		Permanent or Temporary	License received by		Currently in force
		Year issued	Number		Examination	Other	
				☐ Perm ☐ Temp			☐ No ☐ Yes
				☐ Perm ☐ Temp			☐ No ☐ Yes
				☐ Perm ☐ Temp			☐ No ☐ Yes
				☐ Perm ☐ Temp			☐ No ☐ Yes
				☐ Perm ☐ Temp			☐ No ☐ Yes
				☐ Perm ☐ Temp			☐ No ☐ Yes

5. AIDS Education and Training Attestation

I certify I have completed the minimum of seven (7) hours of education in the prevention, transmission and treatment of AIDS. This includes the topics of etiology and epidemiology, testing and counseling, infection control guidelines, clinical manifestations and treatment, legal and ethical issues to include confidentiality, and psychosocial issues to include special population considerations. I understand I must maintain records documenting said education for two (2) years and be prepared to submit those records to the department if requested. **I understand that should I provide any false information, my license may be denied, or if issued, suspended or revoked.**

Applicant's Initials	Date

6. Applicant's Photograph

Photo Here

Attach Current Photograph Here. Indicate Date Taken and Sign in Ink Across Bottom of the Photo.

NOTE: Photograph **Must** Be:

1. Original, not a photocopy
2. No larger than 2" X 2"
3. Taken within one year of application
4. Close up, front view—not profile
5. Instant Polaroid Photographs **not** acceptable

7. Applicant's Attestation

I, ____ , declare under penalty of perjury under the laws of
(Print applicant name clearly)
the state of Washington that the following is true and correct:

- I am the person described and identified in this application.
- I have read **RCW 18.130.170** and **RCW 18.130.180** of the Uniform Disciplinary Act.
- I have answered all questions truthfully and completely.
- The documentation provided in support of my application is accurate to the best of my knowledge.

I understand the Department of Health may require more information before deciding on my application. The department may independently check conviction records with state or federal databases.

I authorize the release of any files or records the department requires to process this application. This includes information from all hospitals, educational or other organizations, my references, and past and present employers and business and professional associates. It also includes information from federal, state, local or foreign government agencies.

I understand that I must inform the department of any past, current or future criminal charges or convictions. I will also inform the department of any physical or mental conditions that jeopardize my ability to provide quality health care. If requested, I will authorize my health providers to release to the department information on my health, including mental health and any substance abuse treatment.

Dated ___________________________________ at ______________________________ (city, state)
mm/dd/yyyy

By: ____
Signature of applicant

Subscribed and sworn to before me this _____________________ day of, 20_____________________

Notary in and for the State of____

Residing at____

Signature of Notary ____

My Commission Expires ____

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License Certification from Dental Examiners Board Secretary for the State in Which Applicant now Licensed

I, ____, Secretary of ______________________________________
Official name of board

hereby certify that ________________________________ was granted State Certification Number

to practice ____ in the state of ___________

on the Month ____________________________ day of ______ , 20 _____________________________________

on the basis of successfully passing the required examination.

Status of License: ☐ Current expiration date _________________
mm/yyyy

☐ Expired Date _________________
mm/yyyy

Type of License Issued: ☐ Full (If ☐ Limited or ☐ Conditional, explain.) ____________________________

____

____

____

Legal/Disciplinary Action, if any: ☐ Yes ☐ No If Yes, explain: ____________________________________

____

____

____

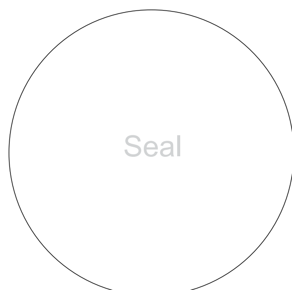
I further certify that the preliminary and professional education of this applicant was verified by this Commission prior to the examination of the applicant.

Acting in behalf of the ____
Official name of board

I hereby certify to the reputability of ____

as it appears on record in this office, and recommend him/her to the Dental Quality Assurance Commission of Washington as a fit and proper person to receive a license.

Secretary's Signature ______________________________________ Date Certification Prepared ___________



Return to: Department of Health
Dental Quality Assurance Commission
P.O. Box 47877
Olympia, WA 98504-7877

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Olympia, WA 98504-7877
360.236.4700

Information Disclosure Authorization

I am applying for a license to practice dentistry in the state of Washington and need documentation from your organization sent to the Department of Health, Dental Quality Assurance Commission to support this application.

I,____ , hereby authorize the following entities to release any pertinent information, derogatory or not, to the Department of Health, Dental Quality Assurance Commission:

☐ American Association of Dental Examiners

☐ National Practitioner Data Bank

Applicant's Signature______________________________________ Date _______________

Applicant: Complete the form, sign, date and return to:

Department of Health
Dental Quality Assurance Commission
P O Box 47877
Olympia, WA 98504-7877

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Olympia, WA 98504-7877
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DEA Authorization

To the Applicant: Fill out this form if licensed in another state.

☐ Please complete the identifying information and submit this form directly to:
Drug Enforcement Administration
Attention: Edie—Diversion Unit
400—2nd Avenue West
Seattle, WA 98119

Date: ___________________________________

To Whom It May Concern:

I am applying for a license to practice dentistry in the state of Washington. Please indicate on the lower portion of this form if there is any derogatory information on file against me. Please send this form directly to the Dental Quality Assurance Commission. Thank you for your assistance.

Name: ____

Date of birth: ____

DEA Registration Number: ____

Address where DEA number is registered: _______________________________________
____
____
____

Applicant's signature ___________________________ Please print name: _____________

Response: ____

DEA—Please forward to:

Dental Quality Assurance Commission
FAX 360.664.9077

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Health Professions Reference RCW, WAC and Links

RCW/WAC Links

Uniform Disciplinary Act........ UDA RCW 18.130

Administrative Procedure Act .... APA RCW 34.05

Administrative procedures and requirements........ WAC 246-12

Dental Professionals RCW .... RCW 18.260

Dentistry WAC .... WAC 246-817

Dentistry RCW........ RCW 18.32

On-Line

AIDS Training .... Reference Page

Dental Quality Assurance Commission .... Web page

Drug Enforcement Administration (DEA)........ www.deadiversion.usdoj.gov

Washington State Dental Association........ www.wsda.org

American Association of Dental Examiners........ www.aadexam.org/

American Dental Association (ADA)........ www.ada.org/

Required Hours of Training

Continuing education (CE) Training after license has been issued........ 21 hours/annually