FLORIDA BOARD OF DENTISTRY
DENTAL RADIOGRAPHY CERTIFICATION APPLICATION

Chapter 466.004 and 466.017(5), Florida Statutes
Rule 64B5-9.011, Florida Administrative Code

SPECIAL NOTES AND INSTRUCTIONS:

1. A **NON-REFUNDABLE fee of $35.00 is required at application**. Please make check or money order payable to the Board of Dentistry and mail to the Department of Health, P. O. Box 6330, Tallahassee, FL 32314-6330. If you need to send additional information that does not include a check or money order, mail it to Department of Health, Board of Dentistry, 4052 Bald Cypress Way, #C08, Tallahassee, FL 32399-3258.
2. Certification requires three (3) months continuous experience assisting in the exposing of radiographs under the **DIRECT SUPERVISION of a Florida licensed dentist** and successful completion of a Board of Dentistry approved course. The approved course must have been completed within 12 months after the on-the-job training. Attach a copy of the certificate you received from the approved course you attended.

TO BE COMPLETED BY THE DENTAL ASSISTANT SEEKING RADIOGRAPHY CERTIFICATION:

PART I – PROFILE DATA

List your full, legal NAME as it should appear on the Radiography Certificate:

FIRST: MIDDLE: LAST:

Date of Birth:	Social Security Number Required: *Enter on separate page provided in the application.*
Telephone: Primary ( )	Business ( )
Mailing address:	
Dentist Name: Dentist Telephone:	[7] Dentist Address: _____ _____ _____ _____

Dates of three (3) months continuous services:

FROM: _____ TO: _____
(Month Day Year) (Month Day Year)

I HEREBY CERTIFY THAT THE ABOVE NAMED DENTAL ASSISTANT HAS BEEN IN MY EMPLOY FOR A MINIMUM OF THREE (3) MONTHS CONTINUOUS SERVICE.

SIGNATURE OF DENTIST & LICENSE NO. _____

FALSE INFORMATION IN THE APPLICATION PROCESS WILL RESULT IN APPLICATION DENIAL AND MAY RESULT IN CRIMINAL CHARGES AGAINST APPLICANT.

SIGNATURE OF APPLICANT: _____

TO BE COMPLETED BY THE DENTAL ASSISTANT SEEKING RADIOGRAPHY CERTIFICATION:

FLORIDA DEPARTMENT OF HEALTH

PART II - PERSONAL AND LICENSURE HISTORY

ALL OF THE FOLLOWING QUESTIONS MUST BE ANSWERED.
If you answer "YES" to ANY of the following questions, explain in full by addendum to the application. You must make a statement that includes, but is not limited to, the date(s), location(s), specific circumstances, practitioners and/or treatment involved, etc., pertaining to the "YES" answer. Any "YES" answer must be substantiated by either official documents sent directly to the board office from the respective state licensing board or official copies of court records. A "YES" answer is NOT an automatic cause for denial of licensure.

NOTE: Obtaining or attempting to obtain a license by bribery, fraud, or knowing misrepresentation is a violation of the Dental Practice Act and may result in the denial of licensure, suspension or revocation of license, and/or other penalty under section 466.028, Florida Statutes, or Rule Chapter 64B5-13, F.A.C.

Have you ever been convicted of, or entered a plea of guilty, nolo contendere, or no contest to a crime in any jurisdiction other than a minor traffic offense? You must include all misdemeanors and felonies, even if adjudication was withheld by the court so that you would not have a record or conviction. Driving under the influence or driving while impaired is not a minor traffic offense for purposes of this question. If yes, please list date, jurisdiction (state and county), offense, disposition, and all other relevant information on reverse side or an attached sheet	YES NO
IMPORTANT NOTICE: Applicants for licensure, certification or registration and candidates for examination may be excluded from licensure, certification or registration if their felony conviction falls into certain timeframes as established in Section 456.0635(2), Florida Statutes. If you answer YES to any of the following questions, please provide a written explanation for each question including the county and state of each termination or conviction, date of each termination or conviction, and copies of supporting documentation to the address below. Supporting documentation includes court dispositions or agency orders where applicable.	
1. Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under Chapter 409, F.S. (relating to social and economic assistance), Chapter 817, F.S. (relating to fraudulent practices), Chapter 893, F.S. (relating to drug abuse prevention and control) or a similar felony offense(s) in another state or jurisdiction? (If you responded "no", skip to #2.)	YES NO
a. If "yes" to 1, for the felonies of the first or second degree, has it been more than 15 years from the date of the plea, sentence and completion of any subsequent probation?	YES NO
b. If "yes" to 1, for the felonies of the third degree, has it been more than 10 years from the date of the plea, sentence and completion of any subsequent probation? (This question does not apply to felonies of the third degree under Section 893.13(6)(a), Florida Statutes).	YES NO
c. If "yes" to 1, for the felonies of the third degree under Section 893.13(6)(a), Florida Statutes, has it been more than 5 years from the date of the plea, sentence and completion of any subsequent probation?	YES NO
d. If "yes" to 1, have you successfully completed a drug court program that resulted in the plea for the felony offense being withdrawn or the charges dismissed? (If "yes", please provide supporting documentation).	YES NO
2. Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under 21 U.S.C. ss. 801-970 (relating to controlled substances) or 42 U.S.C. ss. 1395-1396 (relating to public health, welfare, Medicare and Medicaid issues)?	YES NO
a. If "yes" to 2, has it been more than 15 years before the date of application since the sentence and any subsequent period of probation for such conviction or plea ended?	YES NO
3. Have you ever been terminated for cause from the Florida Medicaid Program pursuant to Section 409.913, Florida Statutes? (If "No", do not answer 3a.)	YES NO
a. If you have been terminated but reinstated, have you been in good standing with the Florida Medicaid Program for the most recent five years?	YES NO

4. Have you ever been terminated for cause, pursuant to the appeals procedures established by the state from any other state Medicaid program (If no, do not answer 4a or 4b.)	YES NO
a. Have you been in good standing with a state Medicaid program for the most recent five years?	YES NO
b. Did the termination occur at least 20 years prior to the date of this application?	YES NO
5. Are you currently listed on the United States Department of Health and Human Services Office of Inspector General's List of Excluded Individuals and Entities?	YES NO
6. If "yes" to any of the questions 1 through 5 above, on or before July 1, 2009, were you enrolled in an educational or training program in the profession in which you are seeking licensure that was recognized by this profession's licensing board or the Department of Health? (If "yes", please provide official documentation verifying your enrollment status.)	YES NO
7. Have you ever been denied the right to take any healthcare license or certification examination in any state?	YES NO
8. Have you ever been refused a license to practice a healthcare profession or any other license or the renewal thereof in any state?	YES NO
9. Have you ever had a license revoked or a certificate of registration to practice a healthcare profession or any other licensed profession revoked, suspended or otherwise acted against (including probation, fine or reprimand) in a disciplinary proceeding in any state?	YES NO

PART III- APPLICANT RELEASE

THE FOLLOWING STATEMENT MUST BE COMPLETED:

APPLICANT RELEASE:

I,_____, state that I am the person referred to in the foregoing Residency/Intern permit application and supporting documentation, that said application and any supporting documentation are true and accurate.

I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past and present), business and professional associates (past and present), and all governmental agencies and instrumentalities (local, state, federal and foreign) to release to the Florida Department of Health any information, files, or records requested by the agency in connection with the processing of this application. I further authorize the Florida Department of Health to release to any organization, individual or group listed above any information which is material to my application.

I understand that it is my responsibility to supplement my application as needed to reflect any material changes in any circumstance or condition stated in the application which might affect the decision of the department and which takes place between the initial filing of the application and the final granting or denial of residency/intern permit.

I have carefully read the instructions and questions in the foregoing application and have answered them completely, without reservations of any kind. Should I furnish any false information in this application, or in any supporting documentation, I acknowledge that such an act constitutes cause for denial, disciplinary action, suspension or revocation of my residency/intern permit to practice dentistry under Chapter 466, Florida Statutes, Chapter 456, Florida Statutes, and Chapter 64B5, Florida Administrative Code, in the State of Florida.

I hereby affirm that I have received, read and understood Chapter 466, Florida Statutes, Chapter 456, Florida Statutes, and Chapter 64B5, Florida Administrative Code, and acknowledge that I must abide by them.

Signature of applicant _____ **Date _____**

CONFIDENTIAL AND EXEMPT FROM PUBLIC RECORDS DISCLOSURE

DEPARTMENT OF HEALTH
FLORIDA BOARD OF DENTISTRY
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This page is exempt from public records disclosure. The Department of Health is required and authorized to collect Social Security Numbers relating to applications for professional licensure pursuant to Title 42 USCA § 666 (a)(13). For all professions regulated under chapter 456, Florida Statutes, the collection of Social Security Numbers is required by section 456.013(1)(a), Florida Statutes.

Name: _____
Last First Middle

Social Security Number: _____

PART IV - APPLICANT HISTORY - HEALTH

If you answer "YES" to any of the following questions, you must submit a current mental health status report from a licensed mental health professional, wherein this professional practitioner opines that you are able to practice with reasonable skill and safety to patients or clients.

A. In the last 5 years, have you been enrolled in, required to enter into, or participated in any drug or alcohol recovery program or impaired practitioner program for treatment of drug or alcohol abuse that occurred within the past 5 years?	❑ YES ❑ NO
B. In the last 5 years, have you been admitted or referred to a hospital, facility or impaired practitioner program for treatment of a diagnosed mental disorder or impairment?	❑ YES ❑ NO
C. During the last 5 years, have you been treated for or had a recurrence of a diagnosed mental disorder that has impaired your ability to practice your profession within the past 5 years?	❑ YES ❑ NO
D. In the last 5 years, were you admitted or directed into a program for the treatment of a diagnosed substance-related (alcohol/drug) disorder or, if you were previously in such a program, did you suffer a relapse within the last 5 years?	❑ YES ❑ NO
E. During the last 5 years, have you been treated for or had a recurrence of a diagnosed substance-related (alcohol/drug) disorder that has impaired your ability to practice your profession within the past 5 years?	❑ YES ❑ NO
F. During the last 5 years, have you been treated for or had a recurrence of a diagnosed physical disorder that has impaired your ability to practice your profession?	❑ YES ❑ NO