Reset Form

APPLICATION FOR DENTAL RESIDENCY PERMIT OR DENTAL FACULTY LICENSE

State Form 57111 (R1 / 3-25)

INDIANA STATE BOARD OF DENTISTRY
PROFESSIONAL LICENSING AGENCY
402 West Washington Street, Room W072
Indianapolis, Indiana 46204
Telephone: (317) 234-2054
E-mail: pla8@pla.IN.gov
www.pla.IN.gov

INSTRUCTIONS: 1. *Completed application and fees should be mailed to the address listed in the upper right hand corner of this form.*
2. *Verification of Enrollment (for Dental Residency) and Verification of Employment (for Dental Faculty) forms are found at the end of this form.*
3. *Please refer to the instructions on our website, www.pla.in.gov, for the licensing requirements.*

* This agency is requesting disclosure of your Social Security Number in accordance with IC 4-1-8-1; disclosure is mandatory and this record cannot be processed without it.

FOR OFFICE USE ONLY	
PERMIT / LICENSE NUMBER	
ISSUE DATE ***(month, day, year)***	
EXPIRATION DATE ***(month, day, year)***	

DO NOT WRITE ABOVE THIS LINE

BASIS OF APPLICATION

Check only one.

☐ Dental Faculty License ☐ Dental Residency Permit

APPLICANT INFORMATION

Name of applicant *(last, first, middle, maiden)*		Social Security Number*
Address *(number and street or rural route number)*		
City	State	ZIP code
Date of birth *(month, day, year)*	Telephone number *(daytime)* ( )	
Email address		

Pursuant to IC 12-32-1-5 and IC 12-32-1-6, I swear under the penalty of perjury that: *(Please select one of the following.)*

☐ I am a United States Citizen. ☐ I am a qualified alien (as defined under 8 U.S.C. § 1641). ☐ I am authorized by the Federal Government to work in the United States.

Are you the spouse of a member of the military who is assigned to a duty station in Indiana? *(Optional)*	Are you an active duty member of the military? *(Optional)*
☐ Yes ☐ No	☐ Yes ☐ No

DEGREE GRANTED BY

Must be an American Dental Association recognized dental program, as determined by the Board.

Name of school	Location of school	Date of graduation *(month, day, year)*

POSTGRADUATE DENTAL EDUCATION

Include internships, residencies, and / or fellowships.

Name of school / program	Location of school	From *(month, year)*	To *(month, year)*

EXAMINATION RECORD

Please select the examinations.

Examination	Check box if exam taken
National Board Dental Exam	☐
North East Regional Board Examination (NERB)	☐
Central Regional Dental Test Services (CRDTS)	☐
Southern Regional Testing Agency (SRTA)	☐
Western Regional Examining Board (WREB)	☐
State Constructed Examination	☐
Canadian Provincial Clinical Licensing Exam	☐

If state board or other examination taken, indicate state and exam type:

LIST ALL STATES, INCLUDING INDIANA, IN WHICH YOU ARE OR HAVE BEEN LICENSED TO PRACTICE ANY REGULATED HEALTH OCCUPATION, REGARDLESS OF STATUS

STATE	TYPE OF LICENSE, CERTIFICATE, REGISTRATION OR PERMIT	NUMBER	DATE ISSUED *(month, day, year)*	CURRENT STATUS

QUESTIONS

If your answer is "Yes" to any of the following, explain fully in a signed written statement, including all related details, and provide copies of all relevant arrest or court documents, disciplinary action against your license or complaints. Describe the event including the location, date and disposition. Falsification of any of the following is grounds for permanent revocation of the license or permit issued pursuant to this application.

1. Has disciplinary action ever been taken regarding any health license, certificate, registration or permit that you hold or have held? ☐ Yes ☐ No
2. Have you ever been denied a license, certificate, registration or permit to practice dentistry / dental hygiene or any regulated health occupation in any state *(including Indiana)* or country? ☐ Yes ☐ No
3. *Except for minor violations of traffic laws resulting in fines, and arrests or convictions that have been expunged by a court,*
   (1) have you ever been arrested; ☐ Yes ☐ No
   (2) have you ever entered into a prosecutorial diversion or deferment agreement regarding any offense, misdemeanor, or felony in any state; ☐ Yes ☐ No
   (3) have you ever been convicted of any offense, misdemeanor, or felony in any state; ☐ Yes ☐ No
   (4) have you ever pled guilty to any offense, misdemeanor, or felony in any state; or ☐ Yes ☐ No
   (5) have you ever pled *nolo contendere* to any offense, misdemeanor, or felony in any state? ☐ Yes ☐ No
4. Are you currently suffering from any condition for which you are not being appropriately treated that impairs your judgment or that would otherwise adversely affect your ability to practice in a competent, ethical, and professional manner? ☐ Yes ☐ No
5. Have you ever been denied staff membership or privileges in any hospital or health care facility or had such membership or privileges revoked, suspended, or subjected to any restriction, probation or other type of discipline or limitations? ☐ Yes ☐ No
6. Have you ever been admonished, censured, reprimanded or requested to withdraw, resign or retire from any hospital or health care facility in which you have trained, held staff membership or privileges or acted as a consultant? ☐ Yes ☐ No
7. Have you ever had a malpractice judgment against you or settled any malpractice action? ☐ Yes ☐ No

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize, request and direct any person, firm, officer, corporation, association, organization or institution to release to the Professional Licensing Agency any files, documents, records or other information pertaining to the undersigned requested by the Agency or any of its authorized representatives in connection with processing my application for licensure.

I hereby release the aforementioned persons, firms, officers, corporations, associations, organizations, and institutions from any liability with regard to such inspection or furnishing of any information.

I further authorize the Professional Licensing Agency to disclose to the aforementioned persons, firms, officers, corporations, associations, organizations, and institutions any information which is material to my application, and I hereby specifically release the Agency from any and all liability in connection with such disclosures.

A photostatic copy of this authorization has the same force and effect as the original.

AFFIRMATION

I affirm, under penalties for perjury, that the foregoing representations are true.

Signature of applicant	Date *(month, day, year)*

APPLICATION FOR DENTAL RESIDENCY PERMIT OR DENTAL FACULTY LICENSE

Part of State Form 57111 (12-21)

VERIFICATION OF ENROLLMENT

(for Dental Residency Permit ONLY)

Return completed form to:

Indiana State Board of Dentistry
Indiana Professional Licensing Agency
402 West Washington Street, Room W072
Indianapolis, IN 46204

* Your Social Security Number is requested by this agency in accordance with IC 4-1-8-1 and it is mandatory that it be given.

THIS SECTION TO BE COMPLETED BY THE APPLICANT		
Name of applicant *(last, first, middle, maiden)*		Social Security Number*
Address *(number and street or rural route number)*		
City	State	ZIP code
Date of birth *(month, day, year)*	Telephone number *(daytime)* ( )	
Email address		

THIS SECTION TO BE COMPLETED BY THE SCHOOL		
Name of school		Name of department
Address *(number and street or rural route number)*		
City	State	ZIP code
Contact person	Title	
Telephone number *(daytime)* ( )	Email address	
Date of residency begins *(month, day, year)*	Date of residency ends *(month, day, year)*	

AFFIRMATION		
I hereby swear or affirm that the applicant listed above is enrolled in a residency or fellowship program and is using the permit only for school purposes. Information provided herein is true and correct.		
Dean / Department chair	Title	
Address *(number and street)*	License number of Dean / Department chair	
City	State	ZIP code
Telephone number ( )	Email address	
Signature of Dean / Department chair		Date signed *(month, day, year)*

APPLICATION FOR DENTAL RESIDENCY PERMIT OR DENTAL FACULTY LICENSE

Part of State Form 57111 (12-21)

VERIFICATION OF EMPLOYMENT

(for Dental Faculty License ONLY)

Return completed form to:

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Indiana Professional Licensing Agency
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Email address		

THIS SECTION TO BE COMPLETED BY THE SCHOOL		
Name of school		Name of department
Address *(number and street or rural route number)*		
City	State	ZIP code
Contact person	Title	
Telephone number *(daytime)* ( )	Email address	
Date of employment begins *(month, day, year)*	Date of employment ends *(month, day, year)*	

AFFIRMATION		
I hereby swear or affirm that the information provided herein is true and correct.		
Dean / Department chair	Title	
Address *(number and street)*		
City	State	ZIP code
Telephone number ( )	Email address	
Signature of Dean / Department chair		Date signed *(month, day, year)*