Reset Form

APPLICATION FOR A LICENSE TO PRACTICE DENTISTRY OR DENTAL HYGIENE

State Form 42127 (R13 / 9-17)
Approved by State Board of Accounts, 2017

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. *The fee for this application is $250.00 for Dentistry in accordance with 828 IAC 0.5-2-3, or $100.00 for Dental Hygiene in accordance with 828 IAC 0.5-2-4; payable to the Indiana Professional Licensing Agency.*
2. *Completed application and fees should be mailed to the address listed in the upper right hand corner of this form.*
3. *All fees are non-refundable and non-transferable.*
4. *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. Social Security numbers are available to the Indiana Department of Revenue.
** This information is being requested for workforce statistical purposes only; disclosure is voluntary.

FOR OFFICE USE ONLY	
LICENSE / EXAM FEE	
DATE FEE PAID *(month, day, year)*	
RECEIPT NUMBER	
LICENSE NUMBER	
LICENSE ISSUANCE DATE *(month, day, year)*	

APPLICANT

Attach two (2) passport type quality photographs of yourself taken within the last eight weeks. Please sign each photo at the bottom. Negatives and Polaroids are not acceptable.

DO NOT WRITE ABOVE THIS LINE

APPLICANT INFORMATION

Name of applicant (*last, first, middle*)		Social Security number *
Date of birth (*month, day, year*)	Place of birth (*city and state or country*)	
Address of applicant (*number and street or rural route*)	City, state, and ZIP code	
Telephone number (*daytime*) ( )	E-mail address	
Gender ** ☐ Male ☐ Female	Ethnicity **	Race **

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).

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

Please check the box to be included on the Health Care Volunteer Registry established by IC 25-22.5-15. *(Optional)* ☐

TYPE OF LICENSE

Applying for licensure by: ☐ Endorsement ☐ Examination
Applying as a: ☐ Dentist ☐ Dental Hygienist

DEGREE GRANTED BY

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

DENTAL / DENTAL HYGIENE PROFESSIONAL EDUCATION

NAME OF SCHOOL	LOCATION OF SCHOOL	DATES ATTENDED (*month, day, year*)

PRE-DENTAL / DENTAL HYGIENE EDUCATION

NAME OF SCHOOL	LOCATION OF SCHOOL	DATES ATTENDED (*month, day, year*)

LIST ALL PLACES OF EMPLOYMENT SINCE GRADUATION FROM DENTAL / DENTAL HYGIENE SCHOOL, INCLUDING SELF-EMPLOYMENT			
NAME AND ADDRESS OF EMPLOYER	**RESPONSIBILITIES**	**HRS / WK**	**DATES**

EXAMINATION RECORD			
National Board Exam ☐ Yes ☐ No	If Yes, how many times?	Date of most recent test *(month, year)*	Where taken *(state or country)*
State Board Exam ☐ Yes ☐ No	If Yes, how many times?	Date of most recent test *(month, year)*	Where taken *(state or country)*
Regional Exam ☐ Yes ☐ No	If Yes, which regional, how many times?	Date of most recent test *(month, year)*	Where taken *(state or country)*
Do you hold, or have you ever held, a license, certificate, registration or permit to practice any regulated health occupation? ☐ Yes ☐ No			

LIST ALL STATES, INCLUDING INDIANA, IN WHICH YOU HAVE BEEN LICENSED TO PRACTICE ANY REGULATED HEALTH OCCUPATION.				
TYPE OF LICENSE	**STATE**	**NUMBER**	**DATE ISSUED**	**CURRENT STATUS**

If your answer is "Yes" to any of the following, explain fully in a sworn affidavit, including all related details, and provide copies of all relevant arrest or court documents. 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 contendre* to any offense, misdemeanor, or felony in any state? ☐ Yes ☐ No
4. Do you have any condition or impairment (including a history of alcohol or substance abuse) that currently interferes, or if left untreated may interfere, with your ability to practice in a competent 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

APPLICATION AFFIRMATION

I hereby swear or affirm, under the penalties of perjury, that the statements made in this application are true, complete and correct.

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

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 a license to practice dentistry or dental hygiene or for an intern permit.

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 such information.

I further authorize the Professional Licensing Agency to disclose to the aforementioned organizations, persons, and institutions any information which is material to my application, and I hereby specifically release the Agency and the Board 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 hereby swear or affirm that I have read the above statements and agree to same.

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