**ARKANSAS STATE BOARD OF DENTAL EXAMINERS**
101 East Capitol Avenue, Suite 111
Little Rock, Arkansas 72201
Phone: 501-682-2085 Fax: 501-682-3543
Web: asbde.org Email: asbde@arkansas.gov

*Place Application Photo Here*

# Application for Temporary Charitable License to Practice Dentistry

For Board Use Only:
Lic. #: _____
DOL: _____

**Please fill out using Adobe Acrobat. Handwritten applications will not be accepted.**

## Personal Data

First Name | Middle Name | Maiden Name | Last Name | Degree

Mailing Address | City | State | Zip

Social Security Number | Home Phone # | Business Phone #

Email Address | Date of Birth | Sex | Race

I am a citizen of the United States by (check one): ☐ Birth ☐ Naturalization ☐ I am not a U.S. citizen.

## Other State Dental Licenses

I am (or have been) licensed to practice Dentistry in the following states/jurisdictions:

| State | Method of Licensure (i.e. examination, credentials) | License Number | Date Licensed | License Expiration Date |
|---|---|---|---|---|
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| NAME OF ARKANSAS LICENSED SUPERVISING DENTIST: | | | |
|---|---|---|---|
| **AR Lic. #** | **Name** | **Address** | **Phone Number** |
| | | | |

| DATES AND LOCATION OF PRACTICE: | | | |
|---|---|---|---|
| **Starting Date** | **Ending Date** | **Location** | **Event** |
| | | | |

## Background History

**If you answer "yes" to any of the following questions, please attach a detailed explanation.**

Have you even been charged with, or convicted of a felony?

☐ Yes ☐ No

Have you ever been charged with, or convicted of, been a party to, or been disciplined for violation of the dental laws of this or any other jurisdiction or professional association?

☐ Yes ☐ No

Are you, or have you ever been, addicted to the use of alcohol, controlled substances or other dangerous drugs?

☐ Yes ☐ No

***Note: As of July 1, 2011, every person applying for a license must authorize the Arkansas State Board of Dental Examiners to conduct a background check through the Arkansas State Police. Information and fingerprint cards will be mailed to you upon receipt of your completed application.***

Please list two (2) character references (neither of whom is related to you):

| Name | Address | Occupation |
|---|---|---|
| | | |
| | | |

In addition to the foregoing:

1. I hereby give my permission for the Arkansas State Board of Dental Examiners to secure information concerning me or any of the statements in this application from any person or any source the Board may desire.

2. I further agree to submit to questions concerning my qualifications as an applicant by the Board or any member thereof, and to substantiate my statements if desired by the Board.

3. By signing this application, I authorize the Arkansas State Board of Dental Examiners to allow the Arkansas State Police to conduct both state and federal background checks on me, and to provide the results of those checks to the board. I will also provide proof of malpractice insurance and have a licensure verification sent from my home state.

4. I agree to read the Dental Practice Act of Arkansas and the Rules & Regulations of the Board pertaining to Dentistry and Dental Hygiene; and I further state that all facts, statements, and answers contained in this application are true and correct; I am not omitting any information which might be of value to this Board in determining my qualifications, whether it is called for or not; and I agree that any falsification, omission or withholding of pertinent information or facts concerning my qualifications as an applicant shall be sufficient to bar me from licensure by the Arkansas State Board of Dental Examiners and such falsification, omission, or withholding shall serve as sufficient grounds for the revocation, cancellation, or suspension of my Arkansas Dental license if it is not discovered until after issuance.

_____ _____

*Signature of Applicant* *Date of Application*