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

PLACE APPLICATION PHOTO HERE

(Headshot or passport photo taken within the last 6 months)

For Board Use:

Lic. #: _____

DOL: _____

Application for License to Practice Dentistry

Please fill out using Adobe Acrobat (or similar application). Handwritten applications will not be accepted.

A. PERSONAL DATA

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

Mailing Address: (Street or PO Box) | 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.

Please check one of the following if it applies to you:

☐ Active duty military service member

☐ Returning military veteran applying within one (1) year of your discharge from active duty

☐ The spouse of an active duty military service member or returning military veteran

B. OTHER STATE DENTAL LICENSES

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

State/Jurisdiction	How licensed	License Number	Date Licensed	Years of Practice

C. EDUCATION

DENTAL EDUCATION:			
Degree	**Dates Attended**	**School**	**Date of Graduation**

D. CLINICAL AND NATIONAL BOARD EXAMINATIONS

Effective January 1, 2020, the Arkansas State Board of Dental Examiners will only accept clinical dental examinations that consist of at least the following components: restorative clinical examination section (anterior and posterior on a live patient), manikin prosthetic section, manikin endodontic section with posterior and interior access, treatment planning, and periodontal section.

Please check which dental clinical examination you successfully passed:
☐ CDCA (Commission on Dental Competency Assessments)
☐ CITA (Council of Interstate Testing Agencies)
☐ CRDTS (Central Regional Dental Testing Service)
☐ SRTA (Southern Regional Testing Agency)
☐ WREB (Western Regional Examining Board)
Date of successful passage of dental clinical examination: _____

Have you successfully completed the National Board Examination? ☐ Yes ☐ No

E. 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

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.

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.

*I have attached a check or money order in the amount of **$8.00** to cover the application fee. I understand that this fee is nonrefundable.*

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*

PHYSICIAN'S STATEMENT OF EXAMINATION OF APPLICANT

Note to applicant: Please have your physician or nurse practitioner complete this form.

I, _____, a duly licensed and practicing physician in the State
(Name of Physician/Nurse Practitioner)

of _____, have this day examined _____
(Name of Applicant)

the applicant herein, and my medical examination reveals that such applicant is free from all infectious and contagious diseases, and such applicant is in sound and good health. This examination made in *(town)* _____ on *(date)* _____, _____.

_____
Signature of Physician or Nurse Practitioner

In accordance with Section 25-19-105 of the Arkansas Freedom of Information Act (FOIA), this form is not open to the public and will not be shared.