MINNESOTA
BOARD OF DENTISTRY

University Park Plaza, 2829 University Ave SE, Suite 450
Minneapolis, MN 55414-3249
Website mn.gov/boards/dentistry
Phone 612.617.2250 - Toll Free 888.240.4762 - Fax 612.617.2260
MN Relay Service for Hearing Impaired 800.627.3529

Appl.# _________
License # ________
Issued _________

APPLICATION FOR LICENSURE TO PRACTICE AS A VOLUNTEER GUEST:

❑ **DENTIST** ❑ **DENTAL HYGIENIST** ❑ **DENTAL ASSISTANT**

❑ **Please check this box, if you have ever held a VOLUNTEER GUEST LICENSE Previously.**

Instructions. Each item on this application must be answered fully, truthfully, and accurately by the applicant. Fraud or deception in securing a license is a gross misdemeanor and is grounds for discipline under the Dental Practice Act. If space for any answer is insufficient, the answer may be completed on another piece of paper. Please specify the number of the item, sign it, and attach it to the rest of the application. BE SURE ALL FOUR PAGES OF THIS APPLICATION AND ITS ATTACHMENTS ARE COMPLETED.

Minnesota Government Data Practice Act Notice. This notice is given pursuant to Minnesota Statutes §13.04, subdivision 2, and §13.41, subdivision 2. In order to be licensed, you must submit all the information requested in this application. The Board will use the information to determine if you meet statutory and rule requirements for licensure. Accordingly, OMISSIONS OR INACCURACIES ARE GROUNDS FOR DENYING YOUR APPLICATION. All data, except your name and address, submitted by you or on your behalf are considered private until you are licensed, at which point the data become public. "Private" is defined by law as information which is accessible only to: you; the staff and members of the Board; the Board's legal counsel; any person to whom the Board must refer the application or parts thereof for verification purposes or for otherwise determining your qualifications; and to persons you designate. In addition, if the matter of your license becomes contested and thereby results either in a contested case hearing or litigation, the data submitted by you or on your behalf may also become accessible to the Minnesota Office of Administrative Hearings, appropriate courts, and those associated with such proceedings, and thereby become publicdata.

Americans With Disabilities Act. It is the policy of the Minnesota Board of Dentistry to comply with the Americans With Disabilities Act (ADA). The ADA provides, in part, that qualified individuals with disabilities shall not be excluded from participating in or be denied the benefits of any program, service or activity offered by the Minnesota Board of Dentistry. If you require additional information about the Minnesota Board of Dentistry's ADA policy please contact the Minnesota Board of Dentistry's designated ADA coordinator.

*****PLEASE TYPE OR PRINT IN INK*****

BACKGROUND

1.	Name (last, first, middle)		Today's Date
2.	Home Address (street)	City, State, Zip	
3.	Telephone (include area code) ( )	Email Address (mandatory)	
4.	Sex ❑ Male ❑ Female	Birth date	Social Security Number - -
5.	Other name(s) by which you are or have been known and reasons for change		

DENTAL EDUCATION

6.	Dental/Dental Hygiene/Dental Assisting School	
7.	Location (City, State)	Date of Graduation (mo, day, year)
8.	Degree (attach a notarized copy of diploma or certificate of completion – if applicable):	

NAME AND LOCATION OF VOLUNTEER GUEST LICENSURE PRACTICE

9.	Name of public health clinic or sponsoring organization promoting volunteer opportunity:	
10.	Clinic or Event Address (street)	City, Zip
11.	Telephone (include area code) ( )	Name (Clinic or Event Coordinator/Director)

		YES	NO
12.	I attest that the care will be provided without compensation.	❑	❑
13.	I understand that a guest license to practice dentistry in Minnesota allows me to practice only at the specific location listed in item 10.	❑	❑
14.	I understand that It will be my responsibility to notify the Board of any changes in the clinic operation/ sponsoring organization with regard to my license.	❑	❑
15.	I understand that it will be my responsibility to notify the Board immediately if my license in any state or other jurisdiction is terminated or disciplined for any reason.	❑	❑
16.	I understand that while practicing under a guest license, I have the same obligations as a dental professional who is licensed in Minnesota and I am subject to the laws and rules of Minnesota and the regulatory authority of its Board.	❑	❑
17.	I have included a letter from the clinic/sponsoring organization that includes a statement, program description or other indication that the clinic/organization provides dental care to patients who have difficulty accessing dental care; and provides a copy of the IRS letter that indicates that the clinic has been established by a nonprofit organization that is tax exempt under chapter 501(c) (3).	❑	❑
18.	I agree to provide dental care to patients who have difficulty accessing dental care, using eligibility criteria established by the public health clinic listed in item 10.	❑	❑

19. EMPLOYMENT – Professional (List each dental practice where you currently practice your profession. Use a separate sheet if necessary.)

	Primary	Secondary	Other
Name of Practice			
Address			
Phone No.			
Supervisor			
Duties			
Average Hours			

PROFESSIONAL BACKGROUND

20. Name any state where you currently practice your profession or previously held a license or been regulated.____________

21.

AFFIDAVIT OF LICENSURE

For each credential listed above, you are required to request each licensing authority to submit to the Minnesota Board of Dentistry an affidavit letter. The affidavit letter must be original and state your name, date of birth, license number, date of issuance, license status and statement regarding disciplinary or corrective actions. Affidavit letters are considered original if they are 1.) Mailed directly from the licensing authority 2.) Emailed directly from the licensing authority or 3.) Verifiable through an online verification portal.

Please check one or more of the following and indicate the state, province or country the affidavit is from:

- ❑ I have included an original affidavit letter with my application
- ❑ An original affidavit letter has been mailed directly to the Minnesota Board of Dentistry at 2829 University Ave SE, Suite 450, Minneapolis, MN 55414
- ❑ An original affidavit letter is being emailed directly to dental.board@state.mn.us
- ❑ The licensing authority has an online verification portal

	YES	NO
22. Have you ever been suspended from practice, reprimanded, censured or otherwise disciplined or disqualified as a dental professional? *(If so, attach a statement indicating reason for action, dates, disposition and address of licensing authority in possession of record.)*	❑	❑
23. Do you have any criminal charges pending against you? *(If so, attach a statement giving full details including reason, dates, name and location of court, and case number.)*	❑	❑
24. Have you ever been convicted of a felony, misdemeanor or gross misdemeanor? *(If so, attach a statement giving full details including reason, dates, name and location of court, and case number, and terms of resolution)*	❑	❑
25. Are there any unsatisfied judgments against you that resulted from the practice of dentistry? *(If so, attach a statement giving details including nature of judgment, dates and reasons for non-payment.)*	❑	❑
26. Based on your assessment or that of another professional, does your use of alcohol or drugs, or the existence of a physiological or psychological medical condition, in any way ever impaired or limited your ability to practice dentistry with reasonable skill and safety?	❑	❑

If yes, please list condition(s):_______________________________________
Is your condition managed or improved with ongoing treatment/physical limitation/therapy? Please explain: _________________________________
____

27. PHOTOGRAPH

For identification purposes, please provide a profile photograph taken within the last 6 months

28. ATTESTATION OF APPLICANT

❑Yes ❑No I attest to the fact that I am fully knowledgeable of the laws of Minnesota including the delegation of duties to allied staff and all other Minnesota Statutes and Rules related to the practice of the dental professions.

❑Yes ❑No I attest to my understanding that I may not practice a dental profession in Minnesota unless and until I receive confirmation from the Board of Dentistry that my Volunteer Guest License has beenissued.

AFFIDAVIT OF APPLICANT

29. STATE OF____________________)
COUNTY OF __________________) ss.

I,______________________________, the applicant being first duly sworn, certify that I am the person referred to in this application for guest dental/dental hygiene/dental assisting volunteer licensure, that under penalty of perjury all the information contained in this application and in any attachment or additional document submitted herewith is true and correct and that all persons and organizations, whether public or private, are authorized to release to the Minnesota Board of Dentistry any information, files or records requested in connection with this application.

APPLICANT'S ORIGINAL SIGNATURE____
(Sign before a Notary Public)

Sworn to before me this________ day of_______________________, 20 ____

My Commission expires____ *(SEAL)*

____
Notary Public Signature

NOTES – PLEASE READ CAREFULLY:

a. Please be sure all FOUR pages of this application are completely filled out. Incomplete applications WILL be returned to you without action pursuant to Minnesota Rule 3100.1500.

b. Remember to attach the required original documents or NOTARIZED photocopies listed in item 6. *(A notarized copy is a photocopy that is certified to be a true copy of the original document and is signed and stamped/sealed by a notary public.)*

c. **Photocopy of current BLS Healthcare provider CPR certification from American Heart Association orAmerican Red Cross.**

d. Remember to attach the required letter from the clinic you will work in (item 9) and an "Affidavit of Licensure" (item 20) from every state/ jurisdiction where you currently work or have ever been licensed/regulated.

e. If you fail to notify the Board of changes in operation of the clinic or sponsoring organization identified in this application, or if you fail to notify the Board of the termination or discipline of your licensure in another jurisdiction, you may be subject to disciplinary action.

_ PLEASE DO NOT WRITE BELOW _

____ DIP ____	____ PHOTO ____	____ LOG
____ EXAMS____	____OTHER____	____COMP ENT
____ JURIS ____	____FEE ____	____CERT

Revised March 2018

June 1, 2018

RE: 2018 Minnesota Mission of Mercy

Thank you for volunteering for the 2018 Minnesota Mission of Mercy event in Minneapolis, Minnesota. Volunteers are the heart of every MOM event – your commitment to travel from outside of Minnesota to treat our patients makes it our privilege to welcome you.

The patients you will be serving are those facing insurmountable barriers to care. Access to dental care is a complex problem for families who are economically disadvantaged, have disabilities, live in remote areas, face cultural and language barriers, or have difficulties navigating government programs. Treatment at MnMOM is <u>not</u> contingent upon the patient providing insurance, financial, or "dental home" information. The Minnesota Mission of Mercy cannot solve the barriers to care issues in Minnesota; however, we can provide access to free dental care and relieve patients of dental pain and infection.

Thank you again for the generous contribution of your time and talents. You will be rewarded ten-fold with the smiles from those whose lives you have touched.

Sincerely,

Alejandro M. Aguirre, DDS, MS
State Chair
Minnesota Mission of Mercy