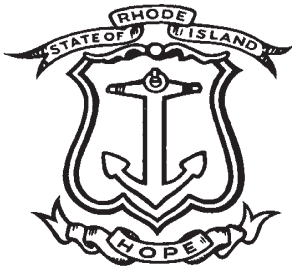
FOR OFFICE USE ONLY
Dental Checklist

- ☐ App. & Fee
- ☐ CSR App. & Fee
- ☐ Birth Certificate
- ☐ Dental Transcript
- ☐ National Board Scores
- ☐ Regional Board/State Board Exam
- ☐ Photograph
- ☐ License Verification
- ☐ AADE Form
- ☐ NPDB Form



*****FOR OFFICE USE ONLY*****

Receipt #

ID #

Issue Date

License #

Rhode Island
Board of Examiners in Dentistry

Room 205
3 Capitol Hill
Providence, RI 02908-5097

License # _____

Name _____

Instructions and License/Permit Application for:

- ☐ **Dentist**
- ☐ **RI Uniform Controlled Substances Registration (CSR)**
- ☐ **General Anesthesia/Deep Sedation**
- ☐ **Moderate Sedation**
- ☐ **Minimal Sedation**
- ☐ **Nitrous Oxide Analgesia**

☐ **Endorsement** ☐ **Examination**

Applicant - Print Name (First/MI/Last)

Phone: (401) 222-2837 **TTY/TDD: (800) 745-5555** **Fax: (401) 222-2158**

Revised 01/09/2013 jcp

GENERAL INFORMATION

Enclosures

The following materials and information should be enclosed within this application packet:

Page

Application Requirements..... 2-4

Instructions for Completing Board Application..... 5-6

Application Materials:

Board Application..... 7-11
Application Checklist..... 12
Rhode Island Uniform Controlled Substances Act Registration (CSR)..... 13
Reciprocity Release Form..... 14
American Association of Dental Examiners Self Query Form..... 15

License Requirements

1. Complete the Board Application pages (7-11). You must respond to all components of the application as instructed. If you attach separate pages in continuation of the Board application, such pages MUST clearly indicate the section for which such information is being reported.

2. Dental License Application Fee - **$965.00** Make a check or money order (in U.S. Funds only), payable to "Rhode Island General Treasurer" and staple it to the upper left-hand corner of the first (Top) page of the application. The application fees are NON-REFUNDABLE. Please be advised that this is an application fee and includes the first license **only** up until the next expiration date. All licenses expire biennally on June 30th of the even numbered years.

3. Obtain licensure verification from all states where you hold, or have ever held, a license to practice dentistry. To obtain this verification, you must mail the Reciprocity Release Form (page 14) to each licensing authority in which you are/were licensed. If you are licensed in Canada, send a copy to each province in which you are/were licensed. Type your information or print in blue or black ball-point pen. Board staff will not make assumptions about illegible information. Be certain to sign and complete the identifying information on each form. **The Board must receive the verification(s) directly from the licensing authority**. Make copies of the form as needed. You may obtain the mailing addresses of all U.S. dental boards and licensing authorities may be obtained at the **American Association of Dental Examiners (AADE)** web site at:

http://www.aadexam.org

or by calling the Board in question. Please do not contact the Rhode Island Board of Examiners in Dentistry for mailing addresses of licensing authorities.

4. Submit a "self-query" of the **National Practitioner Data Bank (NPDB)**. The application is a Practitioner Request for Information Disclosure, which can be obtained by calling the NPDB, or downloading it from the NPDB web site.

Phone Number for NPDB Information:	1-800-767-6732
NPDB web site:	**http://www.npdb-hipdb.com**

You must mail this completed form directly to NPDB. **When you receive a response, send the Board the ORIGINAL, UNOPENED** response. The Board must have this response in order to complete your application so you are encouraged to make this request as soon as possible.

License Requirements Continued

5. Submit the enclosed AADE Self Query form (page 15) to the AADE. You must mail the completed form directly to the AADE. **When you receive a response, send the Board the ORIGINAL UNOPENED** response. The board must have this response in order to complete your application, so you are encouraged to make this request as soon as possible.

6. Official Dental School transcript must be submitted directly to this office by the Dental School.

7. Official Copy of the National Board Scores must be submitted directly to this office by the **American Dental Association (ADA)** (312) 440-2500.

8. Regional or state Board examination results (if applicable).

9. A certified copy of your Birth Certificate (Notarized photo copies are acceptable), If born outside the U.S., proof of citizenship or lawful alien status.

10. A current certificate of completion from an approved course in Basic Cardiac Life Support (BCLS).

Requirements for Additional Registration/Permits

Please review the additional Registration/Permit requirements to determine which, if any, you will need for your practice in Rhode Island.

1. **Rhode Island Controlled Substance Registration (CSR) - Application Fee - $200.00**
In order to dispense, prescribe, store, or order controlled substances, **you must obtain a Rhode Island Controlled Substance Registration (CSR) and a Drug Enforcement Administration (DEA) Registration.** The Rhode Island CSR Application is available on page 13. After you obtain your Rhode Island CSR you must apply for a federal DEA Number. An application for the federal DEA Number can be obtained by contacting DEA: DEA Phone Number (617) 557-2200. Web Site: http://www.deadiversion.usdoj.gov/drugreg/reg_apps/

2. **General Anesthesia/Deep Sedation Application Fee $70.00 - Supporting official transcripts of verification of the qualification requirements listed below and as set forth in Section 16.1.1 of the Rules and Regulations**

   a. Be licensed as a dentist in this state; and

   b. Have completed an advanced training program in anesthesia and related subjects beyond the undergraduate dental curriculum that satisfies the requiements described in the American Dental Association *Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students* (October 2007) [Reference 7]; or

   c. Have completed an American Dental Association accredited post-doctoral training program (e.g., oral and maxillofacial surgery) which affords comprehensive and appropriate training necessary to administer and manage deep sedation/general anesthesia, commensurate with the American Dental Association *Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students* (October 2007) [Reference 7]; or

   d. Be employed or practice in conjunction with a Board certified or Board eligible anesthesiologist.

To view a copy of the Guidelines for Teaching Pain Control and Secation to Dentists and Dental Students please visit the ADA website at: http://www.ada.org/sections/about/pdfs/anxiety_guidelines.pdf

Requirements for Additional Registration/Permits - Continued

3. **Moderate Sedation Application Fee $70.00 - Supporting official transcripts of verification of the qualification requirements listed below and as set forth in Section 16.1.2 of the Rules and Regulations**

   a. Be licensed as a dentist in this state; and

   b. Satisfy one of the following education and training requirements;

      1. Have completed a comprehensive training program in moderate sedation consistent with that prescribed in the American Dental Association *Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students* (October 2007) [Reference 7]; or

      2. Have completed an American Dental Association accredited post-doctoral training program which affords comprehensive and appropriate training necessary to administer and manage moderate sedation; or,

      3. meet one of the requiements as set forth in Section 16.1.1(b) through (d) of these Regulations

   To view a copy of the *Guidelines for Teaching Pain Control and Secation to Dentists and Dental Students* please visit the ADA website at: http://www.ada.org/sections/about/pdfs/anxiety_guidelines.pdf

4. **Minimal Sedation Application Fee $70.00 - Supporting official transcripts of verification of the qualification requirements listed below and as set forth in Section 16.1.3 of the Rules and Regulations**

   a. Be licensed as a dentist in this state; and

   b. Satisfy one of the following education and training requirements;

      1. Have completed a comprehensive training program in minimal sedation that satisfies the requirements as described in the American Dental Association *Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students* (October 2007) [Reference 7]; or

      2. Have completed an American Dental Association accredited post-doctoral training program (e.g., general practice residency) which affords comprehensive and appropriate training necessary to administer and manage minimal sedation; or,

      3. meet one of the requiements as set forth in Section 16.1.1(b) through (d) of these Regulations

   To view a copy of the *Guidelines for Teaching Pain Control and Secation to Dentists and Dental Students* please visit the ADA website at: http://www.ada.org/sections/about/pdfs/anxiety_guidelines.pdf

5. **Nitrous Oxide Analgesia NO Application Fee - Supporting official transcripts of verification of the qualification requirements listed below and as set forth in Section 16.1.5 of the Rules and Regulations**

   a. Be licensed as a dentist in this state; and

   b. meet one of the requirements as set forth in Section 16.1.1(b) through (d) or Section 16.1.2(b) through (d) of these Regulations; or *Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students* (October 2007) [Reference 7] of the American Dental Association, Council on Dental Education and which includes clinical experience in the administration of nitrous oxide analgesia.

   To view a copy of the *Guidelines for Teaching Pain Control and Secation to Dentists and Dental Students* please visit the ADA website at: http://www.ada.org/sections/about/pdfs/anxiety_guidelines.pdf

INSTRUCTIONS FOR COMPLETING THE BOARD APPLICATION

Read the following instructions and those throughout the application packet carefully before completing the Board application. Failure to submit all required information and appropriate documentation may result in processing delays. All of the information provided is subject to change.

General Instructions

1. Make a copy of the application and forms before you begin, in case you make a mistake.

2. Type your information or print in blue or black ball-point pen. Board staff will not make assumptions about illegible information. Be sure to print your name in the box provided on the cover page.

3. Provide a response to each section or question; otherwise, mark "N/A" for Not Applicable.

4. We suggest that you make a copy of your completed application before submitting it to the Board.

5. **It is your responsibility to check on the status of your application.**

Complete all application materials as instructed and arrange them in order as they appear in the application checklist (see page 12). Do not submit applications without all applicable information, documentation and applicable fees. Mail these components of the application to:

Rhode Island Department of Health
Board of Examiners in Dentistry, Room 205
3 Capitol Hill
Providence, RI 02908-5097

Rules and Regulations

To obtain the Rules and Regulations for your profession visit the A-Z list on the Topics & Programs page at the following web site. From the list click on the letter for your profession.

http://www.health.ri.gov/atoz/

Rhode Island General Laws pertaining to the Practice of Dentistry can be obtained at the following web sites:

Dental Licensure **http://www.rilin.state.ri.us/statutes/title5/5-31.1/index.htm**

Controlled Substances Act **http://www.rilin.state.ri.us/statutes/title21/21-28/index.htm**

APPLICATION PROCESS OVERVIEW

The licensure process in the State of Rhode Island is conducted by the Rhode Island Board of Examiners in Dentistry (Board). All licensure applicants must complete and submit a Board application.

Application Process

You must submit your application and supporting credentials directly to the Board. The Board will use this information to assess your qualifications for licensure. Please allow a minimum of 4 weeks for the entire licensure process to be completed. If you have malpractice or disciplinary history, it can take an additional 2 or 3 months for all pertinent documentation to be received.

The Board meets once a month (Except for the month of April). Only applications which are complete, with all supporting credentials, will be forwarded to the Board for review and issuance of a license. Licenses will be issued within 7-10 working days following the Board meeting and are mailed to the address furnished in your application. You are responsible for notifying the Board office, in writing, if your address changes in the interim. Visit the following website to obtain a change of address form.

http://www.health.ri.gov/forms/changeofaddress/professions.pdf

To obtain your license number prior to receiving your license card, please refer to the HEALTH Licensee Lookup web site (Approximately ten (10) days after Board Meeting):

https://healthri.mylicense.com/Verification/

HEALTH will not, for any reason, accelerate the processing of one applicant at the expense of others. Once completed, the application will be reviewed, and you will be contacted in writing.

Please continue to review the remaining portions of this application packet for instructions and other materials necessary to complete the Board application. If you have any questions about this application process, or would like to check on the status of your Board application, please contact this office at (401) 222-2837.

The application process is not considered complete until your Board application, applicable forms and credentials are received in a manner satisfactory to the Board. The Board will not accelerate processing of one applicant at the expense of others for any reason. Once completed, your application will be reviewed and you will be contacted in writing. Be advised that you may be required to appear for an interview. Please allow 7-10 working days following the Board meeting for your wallet size license card to be mailed to you. [**NOTE:** You may not practice dentistry in Rhode Island until you have received a license number.]

State of Rhode Island
Board of Examiners in Dentistry

Application for License to Practice Dentistry

Refer to the Application Instructions when completing these forms. Type or block print only. Do not use felt-tip pens.

1. Name(s)

This is the name that will be printed on your License/Permit/ Certificate and reported to those who inquire about your License/ Permit/ Certificate. Do not use nicknames, etc.

All questions MUST be answered. Enter "NA" for any question that is NOT APPLICABLE.

First Name

Middle Name

Surname, (Last Name)

Suffix (i.e., Jr., Sr., II, III)

Degree (DMD,DDS)

Maiden, if applicable

Name(s) under which originally licensed in another state, if different from above (First, Middle, Last).

2. Social Security Number

U.S. Social Security Number

"Pursuant to Title 5, Chapter 76, of the Rhode Island General Laws, as amended, I attest that I have filed all applicable tax returns and paid all taxes owed to the State of Rhode Island, and I understand that my Social Security Number (SSN) will be transmitted to the Divison of Taxation to verify that no taxes are owed to the State."

3. Gender

☐ Male ☐ Female

4. Date of Birth

Month Day Year 19

5. Home Address

It is your responsibility to notify the board of all address changes.

1st Line Address (Apartment/Suite/Room Number, etc.)

Second Line Address (Number and Street)

City State Zip Code

Country, If NOT U.S. Postal Code, If NOT U.S.

Home Phone Home Fax

Email Address (Format for email address is Username@domain e.g. applicant@isp.com)

6. Primary Business Address

It is your responsibility to notify the board of all address changes.

This address will appear on the Department of Health web site.

Name of Business/Work Location

1st Line Address (Department/Suite/Room Number, etc.)

Second Line Address (Number and Street)

City State Zip Code

Country, If NOT U.S. Postal Code, If NOT U.S.

Business Phone Extension Business Fax

7. Preferred Mailing Address

Please check ONE

☐ Please use my **Home Address** as my preferred mailing address

☐ Please use my **Business Address** as my preferred mailing address

8. Practice Information

A. Specify where in this State you intend to practice, and list type of practice.

Location #1

City

Location #2

City

Location #3

City

9. Practice History

Please provide your practice history for the last five (5) years.

Month	Year		Month	Year	Name and Location of Facility: NOTE: You may continue information on a separate sheet of paper.
		—			
		—			
		—			
		—			
		—			
		—			
		—			
		—			
		—			
		—			

10. Qualifying Education

Please list the name and information about the school that you attended that qualifies you for this license.

Type of School (University, College, etc.)

Name of School

Date Graduated Month Year

Is school accredited by the American Dental Association (ADA)? ☐ Yes ☐ No

Degree Conferred

11. Regional or State Board Examination

Please indicate the type, name and date of your examination

☐ Regional ☐ State

Name of Examination

Date Completed Month Year Passed? ☐ Yes ☐ No

12. National Board Examination

Please indicate the date of your examination and whether you passed.

Date Completed ____ (Month) ____ (Year) Passed? ☐ Yes ☐ No

13. Specialty & Board Certification

Please indicate any specialty that you may have and whether you are certified or not.

Specialty

Board Certified/Qualified?: ☐ Yes ☐ No

If Yes, Year Certified: ____ (Year)

14. Dental Licensure

List all states or countries in which you are now, or ever have been licensed to practice dentistry, or any other profession.

State/Country:			State/Country:		
	☐ Active	☐ Inactive		☐ Active	☐ Inactive
	☐ Active	☐ Inactive		☐ Active	☐ Inactive
	☐ Active	☐ Inactive		☐ Active	☐ Inactive
	☐ Active	☐ Inactive		☐ Active	☐ Inactive

DOCUMENTATION: Send a Reciprocity Release Form to each entity. *(See page 13)*

15. Board Discipline

List any disciplinary actions by licensing boards in other states. Please describe any prior or pending Board action or investigation. Please attach any relevant supplemental materials. If necessary, you may continue on a separate 8 1/2 X 11 sheet of paper.

☐ Check here if not applicable.

Licensing Board (abbreviate) and Nature of Action (e.g. TX - Professional Misconduct):	Month	Year	Type of Discipline:

Please describe any prior or pending Board action or investigation. Please attach any relevant supplemental materials.

16. Criminal Convictions

Respond to the question at the top of the section, then list any criminal conviction(s) in the space provided.

If necessary, you may continue on a separate 8 1/2 X 11 sheet of paper.

Have you ever been convicted of a violation, plead Nolo Contendere, or entered a plea bargain to any federal, state or local statute, regulation, or ordinance or are any formal charges pending; including use of illicit substances or operating a motor vehicle while intoxicated. (Please include any offenses which have been expunged from your record)? ☐ Yes ☐ No

Abbreviation of State and Conviction[1] (e.g. CA - Illegal Possession of a Controlled Substance):

	Month	Year

[1]For purposes of this section, a person shall be deemed to be convicted of a crime if he/she plead guilty or if he/she was found or adjudged guilty by a court of competent jurisdiction or has been convicted of a felony by the entry of Nolo Contendere in any state.

17. Questions

Check either Yes or No for each question.

NOTE: If you answer "Yes" to any question, you are **required** to furnish complete details, including date, place, reason and disposition of the matter.

1.	During any Professional/Dental Education, were you ever dismissed, suspended, restricted, put on probation, or otherwise acted against or did you take a leave of absence for medical reasons?	☐ Yes	☐ No
2.	During any Professional/Dental Education, were you ever requested to leave or did you leave, temporarily or permanently, prior to completion of training?	☐ Yes	☐ No
3.	During any postgraduate training, were you ever dismissed, suspended, restricted, put on probation, or otherwise acted against or did you take a leave of absence for medical reasons?	☐ Yes	☐ No
4.	During any postgraduate training, were you ever requested to leave or did you leave, temporarily or permanently, prior to completion of training?	☐ Yes	☐ No
5.	Are there any charges or investigations pending, in any state, against you?	☐ Yes	☐ No
6.	Have your staff privileges at any hospital, nursing home, or other health care facility or health care provider or HMO ever been reduced, revoked, or suspended or have you voluntarily surrendered your clinical privileges from any such unit or facility while under investigation in any state?	☐ Yes	☐ No
7.	Have you ever had any disciplinary action(s) taken, or is any pending, against your License to practice dentistry, DEA Permit, State Controlled Substances Registration, Medicare Privileges, Medicaid Privileges, or are any complaints pending in any state?	☐ Yes	☐ No
8.	Have you ever had a membership in a professional society revoked, suspended, or limited in any manner or have you voluntarily withdrawn while under investigation?	☐ Yes	☐ No

Note: If you answered "yes" to any of these questions you must submit a written explaination on a separate 8 1/2 X 11" sheet of paper.

18. Administration of Anesthesia

Are you applying for a permit to administer anesthesia in your dental practice? ☐ Yes ☐ No

If yes, Please check the type of permit you are seeking and are qualified for:

☐ General Anesthesia/Deep Sedation ☐ Moderate Sedation

☐ Minimal Sedation ☐ Nitrous Oxide Analgesia

Have you ever been involved in any morbidity or mortality secondary to the administration of general anesthesia/deep sedation, moderate sedation, minimal sedation or nitrous oxide analgesia? ☐ Yes ☐ No

The fees for the above permits are as follows:

General Anesthesia/Deep Sedation	$70.00
Moderate Sedation	$70.00
Minimal Sedation	$70.00
Nitrous Oxide Analgesia	No Fee

In addition supporting official transcripts of verification of the qualification requirements as set forth in the Rules and Regulations must accompany this application.

19. Affidavit of Applicant

Complete this section and sign in the presence of a notary public.

Make sure that you and the notary public have completed all components accurately and completely.

I, _____, being first duly sworn, depose and say that I am the person referred to in the foregoing application and supporting documents.

I hereby authorize all hospital(s), institution(s) or organizations(s), my references, personal physicians, employers (past and present) and all governmental agencies and instrumentalities (local, state, federal or foreign) to release to the Rhode Island Board of Examiners in Dentistry any information which is material to my application for licensure.

I have read carefully both the statute (RIGL 5-31.1) and associated Regulations (R5-31.1 Reg.) for the licensure of dentists in Rhode Island. Further, I have read carefully the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I knowingly furnish any false information in this application, I hereby agree that such act shall constitute cause for denial, suspension or revocation of my license to practice dentistry in the State of Rhode Island.

I understand that this is a continuing application and that I have an affirmative duty to inform the Rhode Island Board of Examiners in Dentistry of any change in the answers to these questions after this application and this affidavit is signed.

_____ _____

Signature of Applicant Date of Signature (MM/DD/YY)

The foregoing instrument was acknowledged before me this _____ day of _____, 20_____, by _____, who is personally known to me or has produced _____ as documentation and did / did not take an oath.

_____ _____

Name of Notary (Print, Type or Stamp) Signature of Notary

Notary Seal

_____ _____

Notary No/Commission No. Commission Expiration Date (MM/DD/YY)

20. Recent Photograph

Securely tape or glue in this square a current 2" x 2" photograph of yourself (alone).

Photographs must be recent, passport type photo, clear, front view, full face without a hat or dark glasses.

Full length photos will not be accepted.

Affix Photo Here

Write your name on the back of the photograph, and provide the date that the photograph was taken.

_____

Date of Photograph

APPLICATION CHECKLIST

Please review the following checklist to ensure you have satisfied all components of the application process. Some items may not apply.

Board Application

- ☐ I have read and understand the "Instructions for Completing the Board Application."
- ☐ I have carefully read RIGL 5-31.1 and R5-31.1REG.
- ☐ I have completed the Rhode Island Board application as instructed (pages 6-10).
- ☐ I have completed Section 19, "**Affidavit of Applicant**" and had the form notarized by a notary public.
- ☐ I have attached a photograph to Section 20, "**Recent Photograph**" as instructed. I have verified that it meets the photograph requirements as stated in the application.
- ☐ I have a **check or money order** made payable (in U.S. funds only) to the "**Rhode Island General Treasurer**" You can combine all fees and submit them in one check. I have attached it to the upper left-hand corner of the first (cover/top) page of the application.

  (Application Fee $965.00)
  (CSR Application Fee $200.00) If applicable
  (**Administration of Anesthesia Permit Fee $70.00 - except for Nitrouos Oxide NO FEE)** If applicable

- ☐ I have arranged my Board Application materials in following order:

  1. Fee (attached as instructed)
  2. Board Application (cover/top page, and pages 7-11)
  3. RI Uniform Controlled Substances Registration (CSR) (page 13, If Applicable)
  4. Supporting documentation as required. [Note: Pages containing additional information in continuation of the Board application MUST indicate the section for which the information is being reported.]

- ☐ I have mailed the above application materials directly to the Licensing Office, Department of Health.

Required Forms / Credentials

- ☐ I have completed and mailed the following forms as instructed:

  1. Reciprocity Release Form(s) (Licensure Verification) (page 14)
  2. Practitioner Request for Information Disclosure (National Practitioner Data Bank)
  3. American Association of Dental Examiners Form (AADE) (page 15)
  4. Copy of current certificate of completion from an approved course in Basic Cardiac Life Support (BCLS)

- ☐ I have requested the following credentials be submitted directly to the BOARD:

  1. Official Dental School Transcript
  2. Official copy of National Board Scores
  3. Official transcript of verification of the qualification requirements for Administration of Anesthesia

Controlled Substances Act Registration (CSR)

***Note:** In order to dispense, prescribe, store, or order controlled substances, you must obtain a **Rhode Island Controlled Substances Act Registration (CSR) and a Drug Enforcement Administration (DEA) Registration.**

The Rhode Island CSR Application is available on page 13. After you obtain your Rhode Island CSR you can apply for a federal DEA Number. An application for the federal DEA Number can be obtained by contacting DEA:

DEA Phone Number: (617) 557-2200.
DEA Web Site: http://www.deadiversion.usdoj.gov/drugreg/reg_apps/

*IF Applying for CSR, this Application **MUST** BE SUBMITTED ALONG WITH YOUR LICENSE APPLICATION.*
Substitute forms are not acceptable

Rhode Island Board of Examiners in Dentistry

Room 205, 3 Capitol Hill
Providence, RI 02908-5097
(401) 222-2837

Rhode Island Uniform Controlled Substances Act Registration (CSR)

I am applying for a Rhode Island Uniform Controlled Substances Act Registration (CSR). **I understand that this application MUST be submitted along with my Board Application . I also understand that there is an additional $200.00 fee for this Registration and that the check or money order for $1,165.00 (NON-REFUNDABLE Board Application fee ($965.00) PLUS CSR Application fee ($200.00)) must be made out to the "RI General Treasurer".**

Print/Type Full Name

Business Name

Signature

Business Address (Must be located in Rhode Island)

Business Telephone

Date

Business Fax

Complete this application for registration to prescribe controlled substances in the State of Rhode Island

The Rhode Island Uniform Controlled Substances Act can be accessed at the following web Site:
http://www.rilin.state.ri.us/Statutes/Title21/21-28/index.htm

Drug Schedule (Check all that apply)

☐ Schedule II ☐ Schedule III ☐ Schedule IV ☐ Schedule V

A CSR is not required if there will be no controlled substances prescriptions prescribed in this state.

The CSR is renewed at the same time that the professional license is renewed.

NOTE:
Read Important Information on the bottom of this application.

A Copy of the DEA Registration must be provided to the Dental Board within 60 Days of its issuance by the DEA. The DEA Registration must be issued to your Rhode Island Practice Address in order for it to be valid. If you are relocating from another state, you need to apply for a DEA Registration that is specific to Rhode Island. See The bottom of this form for information on how to contact DEA.*

All Applicants MUST answer the following:

A. Has the applicant been convicted of, or entered a plea of nolo contendere to a violation of any state or federal law relating to manufacturing, distributing, possessing, prescribing, administering or dispensing of drugs presently defined as controlled substances under Chapter 21-28, General Laws of Rhode Island? ☐ Yes ☐ No

B. Has the registration application or registration of the applicant, corporation, firm, partner, or officer of the applicant been surrendered, revoked, suspended or denied under any law of the United States or of any state relating to drugs presently defined as controlled substances under Chapter 21-28 of the General Laws of Rhode Island, or is such action pending? ☐ Yes ☐ No

If you answered "Yes" to question "A" or "B" attach an explanation to this form.

Important Information

Issuance of a Rhode Island Controlled Substances Registration is contingent upon registration by the U.S. Drug Enforcement Administration. If denied a "DEA Registration", the Rhode Island Controlled Substances Registration becomes "**VOID**". Licensed drug facilities and licensed practitioners with prescriptive privileges cannot dispense, possess, store or ship controlled substances in or into the State of Rhode Island without a valid drug facility or professional license. Rhode Island Controlled Substances Registration (CSR), and a federal Drug Enforcement Administration (DEA) Registration. Practitioners may only prescribe, dispense, possess, and store controlled substances within their particular "scope of practice". "Controlled Substances" for purposes of this application, means a prescription drug in Schedules II through V, pursuant to the Rhode Island Uniform Controlled Substances Act, and 21 CFR 1300 of the Federal Code of Regulations. Schedule I drugs are used by researchers, and require the submission of a protocol.

Without a Rhode Island CSR and federal DEA Registration, licensed drug facilities, and practitioners with prescriptive privileges, may dispense or possess non-controlled prescription medications under its facility or professional license. A CSR will not be granted to an applicant whose BOARD licensure application is "pending" in this state.

A Rhode Island Controlled Substances Registration must be obtained prior to applying for the DEA Registration. Federal regulations require that applicants comply with individual state requirements prior to issuance of a DEA Registration. Once the CSR is issued, applicants must apply to the U.S. Drug Enforcement Administration for a federal registration using that agency's DEA Form 224 (New Application for Retail Pharmacy, Hospital/Clinic, Practitioner, Teaching Institution, or Mid-Level Practitioner). Applicants may apply on-line for the DEA Registration at the following web site: www.deadiversion.usdoj.gov./drugreg/reg_apps/index.html

*You can also receive an application, or check the status of a pending DEA Registration by contacting the Drug Enforcement Administration at the following location: Registration Unit, US Drug Enforcement Administration, JFK Federal Building, 15 New Sudbury Street, Boston, MA 02203-0131, Telephone (888) 272-5174.

NOTE:

- Schedules II, III, and IV of section 21-28-2.08 will become void unless dispensed within thirty (30) days of the original date of the prescription.
- Prescriptions in schedules III, IV and V cannot be written for more that one hundred (100) dosage units and not more than one hundred (100) dosage units may be dispensed at one time. For purposes of this section, a dosage unit shall be defined as a single capsule, tablet or suppository, or not more than one (1) teaspoon of an oral liquid.
- Prescriptions in schedule II may be written for up to a 30-day supply, with a maximum of two hundred and fifty (250) dosage units, as determined by the prescriber's directions for use of the medication.

Substitute forms are not acceptable. This form may be duplicated as needed.

Rhode Island Board of Examiners in Dentistry

Room 205, 3 Capitol Hill
Providence, RI 02908-5097
(401) 222-2837

RECIPROCITY RELEASE FORM

I am applying for a license to practice dentistry in the State of Rhode Island. The Rhode Island Board of Examiners in Dentistry requires that the following form be completed by the jurisdiction in which I am now or was previously licensed. This constitutes your authority to release all information in your files, favorable or otherwise, directly to the Rhode Island Board of Examiners in Dentistry at the above address.

Print/Type Full Name

Signature _____ Date _____

Previous Names Used

Social Security Number 19 Date of Birth

License Number _____ Date Issued _____

THIS SECTION TO BE COMPLETED BY THE DENTAL BOARD

Basis for issuing License:

☐ ADA National Board ☐ NERB ☐ Other Regional Board ☐ State Exam _____ (State)

If a combination of exams were taken, please list the specific combination:

License Status: ☐ Active ☐ Inactive ☐ Lapsed	**Original Date Issued:**	**Expiration Date:**

Questions:

1. Has this dentist ever been investigated by your Board? ☐ Yes ☐ No
2. Has this dentist incurred any disciplinary proceedings in your state, or is any action pending? ☐ Yes ☐ No
3. Has the applicant's license ever been denied, surrendered, reprimanded, suspended, revoked or placed on probation? ☐ Yes ☐ No
4. Are you aware of any information about this dentist submitted to the National Practitioner Data Bank? ☐ Yes ☐ No
5. Do you know of any information that may discredit this person? ☐ Yes ☐ No

If you answer "Yes" to questions 1-5, please provide a written explanation below, and attach a copy of all supporting documentation (e.g., Board order, complaint, etc.).

_____

_____

_____

Certification:

Signature _____ Date _____

Type or Print Name

Please Affix
Board Seal Here

Title

Full Name and of Licensing Board including State

Please return directly to the Board at the above address. Thank you for your prompt cooperation.

AMERICAN ASSOCIATION OF DENTAL EXAMINERS
211 E. CHICAGO AVENUE, SUITE 844
CHICAGO, ILLINOIS 60611
Telephone (312) 440-7464
CLEARINGHOUSE FOR BOARD ACTIONS
Self-Query Form

INSTRUCTIONS: Please type or legibly print in ink the information requested below. A check or money order in the amount of $8.00 (made payable to AADE) along with a notarized copy of this form should be mailed to the American Association of Dental Examiners at the address shown above. A copy of the results will be mailed to you within 10 business days from the date of receipt.

***NAME:** _____
(LAST) (FIRST) (MI) (Suffix)

Alternative Name(s) _____

Mailing Address: _____

_____

Telephone # _____ **DOB:** _____ **SS #** _____

Professional School attended: _____

Year of Graduation _____ **Degree** _____

License No: _____ **State** _____

Other State Licenses Held (Lic. No. and State) _____

DEA #: _____

Information requested must be completed in order to process the self-query. The reliability of reports produced by the Clearinghouse is dependent upon the accuracy and timeliness of the information provided by the reporting entities. The AADE will make no representations or warranties, either expressed or implied, as to the accuracy of the information and will assume no responsibility for errors or omissions that may be contained therein.

Your Signature Notarized

Signature: _____ **Date:** _____

Notary Public Signature: _____

Signed Before me this Date: _____ • **SEAL**

My Commission Expires: _____