SECTION .0700 – INSTRUCTOR'S LICENSE

21 NCAC 16B .0701 INSTRUCTOR'S LICENSE

(a) An applicant for an instructor's license shall submit to the Board:

(1) a notarized application form provided by the Board at www.ncdentalboard.org that includes the information and materials required by Rule .0301(a) of this Subchapter;

(2) the non-refundable instructor's licensure fee set forth in 21 NCAC 16M .0101; and

(3) a statement disclosing and explaining any investigations, malpractice claims, or state or federal agency complaints, judgments, or settlements that are related to licensure and are not disclosed elsewhere in the application.

(b) In addition to the requirements of Paragraph (a) of this Rule, an applicant for an instructor's license shall request the applicable entity to send the following required information or documents to the Board office, with each document in an unopened envelope sealed by the entity involved:

(1) if the applicant is or has ever been employed as a dentist by or under contract with a government agency or a nonprofit or for-profit organization, a certification letter of the applicant's current status and disciplinary history from each agency or organization where the applicant is or has been employed or under contract;

(2) a certificate of the applicant's licensure status from the dental regulatory authority or other occupational or professional regulatory authority and information regarding all disciplinary actions taken or investigations pending, from all licensing jurisdictions where the applicant holds or has ever held a dental license or other occupational or professional license;

(3) a report of any pending or final malpractice actions against the applicant, verified by the malpractice insurance carrier covering the applicant;

(4) a letter of coverage history from all current and all previous malpractice insurance carriers covering the applicant; and

(5) a certification letter from the dean or director that the applicant has met or been approved under the credentialing standards of a dental school or an academic medical center with which the person is to be affiliated, and certification that the school or medical center is accredited by the American Dental Association's Commission on Accreditation or the Joint Commission on Accreditation of Health Care Organizations.

(c) The Board shall receive all information and documentation set forth in Paragraphs (a) and (b) of this Rule for the application to be complete. Applications that are not completed within one year of being submitted to the Board shall be disregarded as expired without a refund of the application fee.

(d) Any applicant who changes his or her address shall notify the Board office in writing within 10 business days.

(e) Any license obtained through fraud or by any false representation shall be revoked.

History Note: *Authority G.S. 90-28; 90-29.5;*
Temporary Adoption Eff. January 1, 2003;
Eff. January 1, 2004;
Recodified from 21 NCAC 16B .0601 Eff. March 1, 2006;
Amended Eff. September 1, 2014;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. January 9, 2018;
Amended Eff. March 1, 2020.

North Carolina State Board of Dental Examiners
2000 Perimeter Park Drive - Suite 160 - Morrisville, NC 27560
(919) 678-8223

APPLICATION FOR AN INSTRUCTOR'S LICENSE

MATERIALS TO BE SUBMITTED
(Retain this Page for Your Records)

The materials listed below must be received by the Board office as a complete package, with each document in an unopened officially sealed envelope from the entity involved. Digital copies sent directly from the entity will be accepted via email to applications@ncdentalboard.org. Any applications that are received incomplete may be delayed!

1) Verification of present or past employment as a dentist by or under contract with any agency or organization. Verification must include current status and any disciplinary history.

2) Applicants licensed to practice dentistry in another state/jurisdiction must submit a National Practitioner Data Bank Report. Please contact the National Practitioner Data Bank at **www.npdb-hipdb.hrsa.gov** or 1-800-767-6732.

3) If applicable, a report of any pending or final malpractice actions verified by the malpractice insurance carrier along with all documents and records and verification of coverage history from current and all previous malpractice insurance carriers. If you have never carried your own coverage, please attest in a written statement.

4) Verification of a valid, current and unrestricted general dental or dental specialty license in any state, territory, country or other jurisdiction. **(Copies of your license and/or renewal certificates are NOT acceptable.)**

In addition to the items listed above, the materials listed below must also accompany the application. These items do not need to be in sealed envelopes.

5) Instructor's Fee - $140.00
CERTIFIED CHECK OR MONEY ORDER ONLY (Payable to: NC State Board of Dental Examiners)
THIS FEE IS NON-REFUNDABLE!! The application fee is nonrefundable and nontransferable and shall not be returned to you under any circumstances. This means that even if your application is denied, or you are offered a Consent Order by the Board, or you petition the Board for a formal hearing, the application fee will not be refunded.
"If your check is not paid on presentment or is dishonored, you agree to pay the amount allowed by state law. We may electronically debit or draft your account for this charge. Also, if your check is returned for insufficient or uncollected funds, your check may be electronically re-presented for payment."

6) One passport-size photograph, taken within the last six months, glued to the application form. **Do NOT send Polaroid snapshots.**

7) A signed release form, completed Fingerprint Record Card, and other such form(s) required to perform a criminal history check at the time of application. **Please request forms by email; send mailing address to info@ncdentalboard.org.**

8) An employment verification letter from the dean or director of the dental school or academic medical center in which you be affiliated.

Please Note!! The Board's rules constantly change. While every effort is made to keep rules and statutes up to date in this and other documents, always check for the latest version of the Board's rules directly from the Office of Administrative Hearings' website. A link to their page may be found on our website on the "Rules and Laws" page.

NORTH CAROLINA STATE BOARD OF DENTAL EXAMINERS

A photograph of you, not less than 2x2 (snapshot not acceptable) taken not more than six months prior to the date of application, must be securely glued (NOT STAPLED) to this space and must NOT be larger than the space provided. A passport photograph is acceptable.

APPLICATION

INSTRUCTOR'S LICENSE

PLEASE TYPE OR PRINT LEGIBLY

Each question must be answered fully, truthfully and accurately. All supporting data requested must accompany this application. If the space for any answer is insufficient, you must complete your answer on a rider signed by you, specifying the number of the question to which it relates and enclosing it with this application. ***DO NOT SEPARATE THIS FORM AND DO NOT STAPLE ENCLOSURES TO THIS APPLICATION !***

1. _____

   (First Name in Full) (Middle/Maiden) (Last Name in Full)

   _____

   (Present Street Address) (City) (State) (Zip) (County)

   _____

   (Permanent Street Address) (City) (State) (Zip) (County)

2. Preferred mailing address for **ALL information:** _____Present _____Permanent
3. Telephone number (day): ( ) _____ Email address:_____
4. Age:_____ Date of Birth:_____/_____/_____ Place of Birth:_____
5. Are you a citizen of the United States of America? _____Yes _____No
6. Social Security Number: _____-_____-_____
7. Are you (check one): _____Single _____Married _____Divorced
8. Have you ever been known by another name? _____Yes _____No

   If yes, state in full every other name by which you have been known: (If change was made by a Court order, enclose a certified copy of such order)

   _____

9. Please list all resident addresses for the past 10 years (Attach a separate sheet if necessary):

CITY	STATE	DATES RESIDED

10. Name two individuals who will always know your address:

Name:_____ Name:_____

Address:_____ Address:_____

_____ _____

Phone:( )_____ Phone:( )_____

11. Have you ever declared bankruptcy? _____Yes _____No

If yes, please explain: (Attach a separate sheet if necessary):_____

_____

12. Please list any current and past drivers licenses you have maintained:

(DL#)_____(State)_____(Dates Maintained)_____

(DL#)_____(State)_____(Dates Maintained)_____

13. a) Have you previously applied for the dental examination given in North Carolina?

_____Yes _____No If yes, give date(s):_____

b) Have you previously applied for any dental permit in North Carolina? _____Yes _____No

If yes, please provide dates and type of dental permit_____

c) Have you failed an examination given by North Carolina or another Board? _____Yes _____No

If yes, please give Board(s) and date(s):_____

d) Have you ever been refused any examination given by North Carolina or another Board?

_____Yes _____No If yes, give Board(s) and date(s):_____

e) Have you taken the Dental National Board Examination? _____Yes _____No _____Pending

If yes or pending, please list date(s):_____

f) Have you ever failed the Dental National Board Examination? _____Yes _____No

If yes, please list date(s):_____

g) Have you ever taken a regional board examination? _____Yes _____No

If yes, please list examination(s) and date(s):_____

14. Please list all jobs held within the past 10 years, other than dentistry, and, if terminated or asked to leave from that position, please explain. (Attach a separate sheet if necessary)

OCCUPATION	EMPLOYER W/ADDRESS & PHONE	DATE OF EMPLOYMENT	REASON FOR LEAVING

15. I am currently or have been licensed to practice dentistry in the following jurisdictions:

Jurisdiction *(State/Province/Territory)*	How Licensed . *(Exam, Reciprocity)*	License/Permit Number	Date of Issuance	Years of Practice

16. Have you ever been a member of a state dental society? _____Yes _____No

If yes, please list status and dates of membership_____

17. As a dentist, a member of any professional or other organization, or as a holder of any public office:
    a) Have you been suspended or otherwise disqualified or have a pending appeal of a determination of suspension or disqualification? _____Yes _____No
    b) Have you been reprimanded, censured or otherwise disciplined, or have a pending appeal of a reprimand, censure or other disciplinary action? _____Yes _____No
    c) Have any charges or complaints, formal or informal, been made or filed against you, or have any proceedings been instituted against you? _____Yes _____No
    d) Have you ever been reported to the National Practitioner Data Bank or the HIP (Health Care Integrity and Protection) Data Bank? _____Yes _____No

If your answer is yes to any of the foregoing questions, for each occurrence furnish a written statement giving the complete facts and state as to each case the date, the nature of the charge, the disposition of the matter, and the name and address of the authority in possession of the records.

18. Are you a Diplomate, board-eligible or declared specialist in any branch of dentistry? ____Yes ____No

If yes, give specialty and how qualified_____

19. Have you undertaken any post graduate training or refresher course other than continuing education courses since receiving your dental degree? _____Yes _____No

If yes, give place, date, and courses:_____

20. Have you been dropped, suspended, expelled, or disciplined by any school or college for any cause whatsoever? _____Yes _____No

If yes, on a separate sheet of paper list date, school and nature of cause.

21. Have you ever been denied admission to any college or school for cause that reflects adversely on your character? _____Yes _____No

22. Have you ever served in the armed forces of the United States or any other country? _____Yes _____No

a) Have you been separated from such services? _____Yes _____No
b) State nature of separation_____
c) If other than honorable, furnish a written statement, specifying type thereof, and circumstances surrounding your release.
d) State inclusive dates of service_____
e) In the armed services, have any charges or complaints, formal or informal, been made or filed against you, or have any proceedings ever been instituted against you, or have you ever been a defendant in any court martial? _____Yes _____No
If yes, please attach on a separate sheet of paper date an explanation of each incident.
f) Have you registered under the Selective Service Act of 1948? _____Yes _____No

23. Have you ever been:

a) been summoned to court or before a magistrate for the violation of any law or ordinance or for the commission of any felony or misdemeanor? ____Yes ____ No

b) been arrested for the violation of any law or ordinance or for the commission of any felony or misdemeanor? ____Yes ____ No

c) been taken into custody for the violation of any law or ordinance or for the commission of any felony or misdemeanor? ____Yes ____ No

d) been indicted for the violation of any law or ordinance or for the commission of any felony or misdemeanor? ____Yes ____ No

e) been convicted or tried for the violation of any law or ordinance or for the commission of any felony or misdemeanor? ____Yes ____ No

f) been charged with the violation of any law or ordinance or for the commission of any felony or misdemeanor? ____Yes ____ No

g) pleaded guilty to the violation of any law or ordinance or for the commission of any felony or misdemeanor? ____Yes ____ No

If your answer is yes to any of the foregoing questions, attach a statement describing fully the nature of any such matters, with complete facts, disposition of the matter, and the name and address of the authority in possession of the records thereof. Only traffic violations unrelated to alcohol or drugs may be excluded from this answer.

24**.** Within the past five years, have you exhibited any conduct or behavior that could call into question your ability to practice [dentistry/dental hygiene] in a competent, ethical, and professional manner?
□ Yes □ No
If you answered yes, furnish a thorough explanation below:
*Explanation:*_____
_____
_____
_____
Relevant date(s): _____

25. **A.** Do you currently have any condition or impairment (including, but not limited to, substance abuse, alcohol abuse, or a mental, emotional, or nervous disorder or condition) that in any way affects your ability to practice dentistry in a competent, ethical, and professional manner? □ Yes □ No

B. If your answer to Question 25(A) is yes, are the limitations caused by your condition or impairment reduced or ameliorated because you receive ongoing treatment or because you participate in a monitoring or support program? □ Yes □ No

If your answer to Question 25(A) or (B) is yes, complete separate **release and summary forms** for each service provider that has assessed or treated any such condition or impairment. **Release and summary forms** are attached and may be duplicated as needed. As used in Question 25, "currently" means recently enough that the condition or impairment could reasonably affect your ability to function as a dentist.

26. If you have been admitted to practice in any jurisdiction, provide the following certification and make a complete statement of all your practice since graduation to date. Include temporary or part-time work. Indicate:
    1) The dates during which you were employed as a dentist or engaged in practice.
    2) The addresses of the offices or places at which you were so employed or engaged, and the names and addresses of all employers, partners, associates, or persons sharing office space, if any (Attach sheet if necessary)
    3) The nature of your practice. (General Dentistry or Specialty)
    4) The reason for the termination of each employment or period of private practice.

FROM	TO	NAME AND ADDRESS OF EMPLOYER/ASSOCIATES	NATURE OF PRACTICE	REASON FOR LEAVING

27. a) Do you now, or have you ever held any other health care license? _____Yes _____No
(Example: medical, dental hygiene, chiropractic, etc.)
If yes, give type of license, State, and dates held_____

b) Has this license(s) ever been suspended or revoked? _____Yes _____No
If yes, give dates and reasons_____

28. Have your hospital privileges (for any license) ever been revoked or suspended? _____Yes _____No

If yes, give dates, locations and reasons_____

29. a) Have you ever held a DEA license? ___Yes ___No

b) Has your DEA license ever been revoked, suspended or surrendered? ___Yes ___No

If yes, give dates, locations and reasons_____

DENTAL EDUCATION

NAME AND LOCATION OF SCHOOL ATTENDED	PERIOD OF ATTENDANCE (i.e. Sept. 1990 to Sept. 1994)
1st Year	
2nd Year	
3rd Year	
4th Year	

I received the degree of_____from_____on
(College or University)
the_____day of_____.
(Date) (Month/Year)

POST GRADUATE EDUCATION

NAME AND LOCATION OF SCHOOL ATTENDED	PERIOD OF ATTENDANCE (i.e. Sept. 1990 to Sept. 1994)
1st Year	
2nd Year	
3rd Year	
4th Year	

I received the degree of _____from_____on the
(College or University)
_____day of _____.
(Date) (Month/Year)

30. In addition to the foregoing, I add the following:

a) I solemnly declare upon my honor that if granted an instructor's license to practice dentistry in North Carolina, I shall respectfully comply with all laws regulating the practice of dentistry in this State, and will do my best to uphold and maintain the ethics of the profession.

b) I hereby give permission to the North Carolina State Board of Dental Examiners to secure additional information concerning me or any statement in this application from any person or any source the Board may desire. I further agree to submit to questions by the Board or any member or employee thereof, and to substantiate my statements if desired by the Board.

c) I have attached the required fee for an instructor's license. **(DO NOT SEND CASH)** I understand that the fee are nonrefundable and nontransferable.

d) **I understand that my application will NOT be accepted if ALL materials are not received as a complete package. Further, I understand that the application, all materials and the fee will be returned if the application package is not accepted for lack of completion.**

In order to determine my suitability for a license to practice dentistry in North Carolina, I understand that the North Carolina State Board of Dental Examiners must make a thorough investigation of my personal records and employment history. It is in the public's best interest that any and all relevant information concerning my personal and employment history be disclosed to the North Carolina State Board of Dental

Examiners. Therefore, I do hereby request and authorize any former and present employers, educational institutions, doctors or other health care professionals including mental health, alcohol treatment centers, hospitals or other repositories of medical records, government agencies, criminal and civil courts, including any private law firms and or certification/licensing boards or commissions, any other individual agency or firm to produce and provide true copies of any and all information and documents, including but not limited to privileged or confidential documents to the Board regarding myself.

I hereby expressly waive all provisions of law forbidding any physician or other person who has attended or examined me, or who may hereafter attend or examine me, from disclosing any knowledge or information which he thereby acquired; and I hereby consent that he may disclose such knowledge or information to the North Carolina State Board of Dental Examiners.

Moreover, I hereby release the Board from any civil or criminal liability whatsoever for seeking such requested information and for evaluating such information as it relates to my application and potential license. I hereby release the issuing agency and its agents, both individually and collectively from any and all liability for damages of whatever kind, which may at any time result because of compliance with this request.

I further waive all rights to inspect or review any and all information compiled in reference to any investigation or application for license. I do further hereby authorize the Board, its agents and employees, to release true copies of any and all information to any agency or entity regulating the licensing authority of the practice of dentistry.

I hereby acknowledge that this authorization is truly voluntary and is valid for one (1) year or until the application and/or investigation process has been completed. A true copy of this document is considered valid, just as the original.

I understand that this application is a continuing application and that I must provide full and correct answers to the questions herein. I will notify the Board of any changes relating to any matter inquired about herein.

I understand that failure to provide full and correct answers and/or failure to update my responses will be grounds for denial of my application or revocation of my license.

I have read and fully understand the above statements.

_____

(Signature)

_____

(Print Name)

I,_____, the applicant herein depose and say that all facts, statements, and answers contained in this application are true and correct to the best of my knowledge. I am not omitting any information which might be of value to this Board in determining my qualifications and character, whether it is called for or not; and I agree that any falsification or withholding of information or facts concerning my qualifications as an applicant shall be sufficient to bar me from an instructor's license or any future examination given by the North Carolina State Board of Dental Examiners, and such falsification or withholding shall serve as sufficient grounds for the suspension or revocation of my North Carolina dental license even though it is not discovered until after issuance.

State/Territory/Jurisdiction of _____

County/Province of_____

I_____, a Notary Public for said County/Province and State/Territory/Jurisdiction, do hereby certify that_____personally appeared before me this the_____day of_____,_____ and acknowledged the due execution of the foregoing instrument.

Witness my hand and official seal, this the_____day of_____,_____.

_____
Notary Public

My commission expires:_____

(SEAL)

North Carolina Law now requires that all applicants and those renewing a license respond to the following statement:

Public Notice Statement

required by N.C. Gen. Stat. § 143-764(a)(5), effective December 31,2017

Any worker who is defined as an employee by N.C. Gen. Stat. §§ 95-25.2(4)(NC Department Of Labor), 143-762(a)(3)(Employee Fair Classification Act), 96-1(b)(10)(Employment Security Act), 97-2(2)(Workers' Compensation Act), or 105-163.1(4)(Withholding; Estimated Income Tax for Individuals) shall be treated as an employee unless the individual is an independent contractor. Any employee who believes that the employee has been misclassified as an independent contractor by the employee's employer may report the suspected misclassification to the Employee Classification Section within the North Carolina Industrial Commission.

Employee Classification Section
North Carolina Industrial Commission
1233 Mail Service Center
Raleigh, NC 27699-1233
Telephone: (919) 807-2582
Fax: (919)715-0282
Email: emp.classification@ic.nc.gov

Employee misclassification is **defined** as avoiding tax liabilities and other obligations imposed by Chapter 95, 96, 97, 105, or 143 of the North Carolina General Statutes by misclassifying an employee as an independent contractor. *[N.C. Gen. Stat. § 143-762(5)]*

I certify that I have read and understand the Public Notice Statement from the North Carolina Industrial Commission appearing above regarding the classification of employees.

_____Yes **_____No**

I further certify that I (_____have) (_____have not) been investigated for employee misclassification within the past three (3) years.

If you <u>have been</u> investigated for employee misclassification within the past three years, you must submit the results of that investigation to the North Carolina State Board of Dental Examiners before your license renewal will be considered complete.

DO NOT ALTER THIS FORM
Corrections/erasures VOID this form
Please use black or blue ink

To be used with Question 24 and 25

*Applicant's name*_____

*Name of institution, doctor, or counselor*_____

*Address*_____

*City*_____ *State*_____ *Zip*_____

*Country*_____ *Province*_____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION FORM

By signing below, I authorize the above provider to provide information, without limitation, relating to mental illness or the use of drugs and alcohol concerning advice, care, or treatment provided to me, to representatives of the Board of Dental Examiners of the State of North Carolina who are involved in conducting an investigation into my moral character, professional reputation, and fitness for the practice of law. I understand that any such information as may be received will be reported only to the admitting authority. The information will be used or disclosed at my request. This authorization will expire one year from the date of my notarized signature below. A photocopy of this form is acceptable for purposes of obtaining this information.

I hereby release, discharge, and exonerate the Board of Dental Examiners of the State of North Carolina, its agents and representatives, the admitting authority, its agents and representatives, and the above named provider, its agents and representatives so furnishing information from any and all liability of every nature and kind arising out of the furnishing or inspection of any documents, records, and other information, or out of the investigation made by the Board of Dental Examiners of the State of North Carolina or by the admitting authority.

I am not required to sign this authorization in order to receive treatment from the above provider. I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the provider has acted in reliance upon this authorization. My written revocation must be resubmitted to the Director of Investigations at the address of the provider above.

_____

Signature of Applicant *Date*

STATE/DISTRICT OF _____

COUNTY OF _____

Subscribed and sworn to or affirmed before me this _____day
of _____, _____
Month *Year*

_____

Signature of Notary

My commission expires _____

Seal or stamp must be affixed to each original.

The Board of Dental Examiners of the State of North Carolina is aware of HIPAA requirements.

Revised 08/08/2018

To be used with Question 24 and 25

DESCRIPTION OF CONDITION OR IMPAIRMENT FORM

Name _____

First *Middle* *Last* *Suffix*

Relevant dates: From Mo/Yr _____ To Mo/Yr _____

Describe the condition or impairment _____

_____

_____

_____

_____

_____

_____

Describe any treatment, or any program that includes monitoring or support _____

_____

_____

_____

_____

Name and complete address of attending physician or counselor (if applicable):

Name of physician or counselor _____

Physician's or counselor's current address _____

_____

City _____ *StateZip* _____ *Country* _____

_____ *Province* _____

Telephone (___)_____

Name and complete address of hospital or institution (if applicable):

Name of hospital or institution _____

Hospital's or institution's current address _____

_____

City _____ *StateZip* _____ *Country* _____

_____ *Province* _____

Telephone (___)_____

The Board of Dental Examiners of the State of North Carolina is aware of HIPAA requirements.