



Ohio State Dental Board

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LIMITED RESIDENT'S LICENSE

Section 4715.16 of the Ohio Revised Code, provides that . . . "Upon payment of a fee of ten dollars (\$10.00), the state dental board may, without examination, issue a limited resident's license to any person who is a graduate of a dental college, and who is authorized to practice in another state or country or qualified to take the regular licensing examination in this state, and who furnishes the board satisfactory proof that he has been appointed a dental resident at an accredited dental college in this state or at an accredited program of a hospital in this state, but who has not yet been licensed as a dentist by the board. Any person receiving such limited resident's license may practice dentistry only in connection with programs operated by the dental college or hospital at which he is appointed as a resident as designated on his limited resident's license, and only under the direction of a licensed dentist who is a member of the dental staff thereof, or a dentist holding a current limited teaching license pursuant to division (B) of this section, and only on bona fide patients of such programs. The holder of a limited resident's license may be disciplined by the board pursuant to section 4715.30 of the Revised Code."

Proof of inoculation against or immunity to hepatitis B *must* accompany the application.

Color Passport type photograph must be attached to the application.

Resident's license applications must be reviewed and approved by the Board. This procedure is followed at regularly scheduled Board meetings. The applicant will not be permitted to practice until the license has been issued.

A limited resident's license is valid from July 1st of the year of issue, through the end of the residency program. ***If there is a change in the residency program, a new application must be completed and submitted.***

APPLICATION FEES ARE NONREFUNDABLE, EVEN IN THE EVENT THAT THE APPLICATION IS SUBSEQUENTLY DENIED OR WITHDRAWN.

If you have any questions concerning these instructions, please do not hesitate to call the board office.

Certificate of Dental College

12. I hereby certify that _____ matriculated in _____
Name of Applicant
Dental College on _____, _____. He/She attended and successfully completed
a full course in dentistry and graduated with the degree of DDS/DMD on the _____ day of _____,
_____. I further certify that I know of no reason why the applicant should not be granted a limited resident's license in
the State of Ohio.

SEAL Signature of Dean _____ Date _____

Jurisdictions in which Applicant is Licensed

13. I am licensed to practice dentistry in the following jurisdictions and no others:

Jurisdiction	How Licensed	License No.	Date of Issuance	Years of Practice

14. I have been refused dental licensure by the following jurisdictions and no others, for the following reasons:

Practice History

15. Provide the following certification and make a complete statement of all your practice since graduation to date. Include temporary or part-time work. State as to each employment or period of practice. (Use an extra sheet of paper, if necessary.)

A. The periods during which you were employed as a dentist, or engaged in the private practice of dentistry, with the dates. _____

B. The address of the offices or places at which you have been employed or engaged, and the names and addresses of all employers. _____

C. The nature of your practice. (If your present practice is limited to a specialty, list the specialty.)

D. The reason for the termination of each employment for dentist. _____

Certificate of Secretary of Board of Dental Examiners of the State in which Applicant is Now Licensed (if other than Ohio)

16. If you are presently licensed in more than one state, provide the following certification from the last state in which you attained licensure, or the one in which you now practice. (Other states should provide letters of certification.)

I, _____ Secretary of _____
(Official Name of Board)

hereby certify that _____ was granted state certificate number _____
to practice dentistry in the State of _____ on the _____ day of _____,
to the basis of _____ examination or _____ Criteria Approval.

Acting on behalf of _____, I hereby certify to the reputability of the applicant as appears
(Official Name of Board)
on record in this office, and recommend him/her to the Ohio State Dental Board as a fit and proper person to receive a license. I further certify that I know of no reason why this applicant should not be licensed to practice dentistry in the state of Ohio.

Date _____ Signature of Board Secretary _____ **SEAL**

17. Have you been entitled to practice in each of the jurisdictions specified under question 13, continuously from the date you first became entitled until the present? If NO, why? Yes No

18. Have you been suspended from practice, reprimanded, censured, or otherwise disciplined or disqualified as a dental hygienist or a member of any profession? If YES, state the dates, the facts, the disposition of the matter and the name and address of the authority in possession of the record thereof. (ATTACH STATEMENTS) Yes No

19. A. Have you been convicted of or plead guilty to any felony or misdemeanor? (Exclude all traffic violations other than those involving driving while under the influence of alcohol or other drugs.)? If YES, attach statements giving dates and disposition. Yes No

B. Do you have any criminal charges pending against you? If YES, attach statement giving details of the matter and the name and address of the authority in possession of the record thereof. Yes No

20. Have you ever been treated for mental illness on an outpatient basis, or been confined to any sanitarium, hospital or mental institution for the treatment of mental illness? If YES, attach statements, giving full explanation, including name and address of doctor and institution. Yes No

21. Are you now, or have you ever been addicted to, or have you received treatment for, the habitual use of narcotics or alcohol? If YES, attach statement giving full explanation, dates, places, etc. Yes No

22. Are you currently immune to, or have you received inoculation against the hepatitis B virus? If YES, attach documentary evidence of same. If NO, you are required to submit proof of immunity to or inoculation prior to commencing patient contact. Yes No

Medical Report

23. I, _____, a duly licensed physician in the state of _____, have this day examined _____, and my medical examination reveals that to the
Name of Applicant
best of my knowledge, the applicant is not dependent on narcotic drugs or alcohol. Moreover, I find that the applicant has no physical or mental DISABILITIES except: _____. The examination was made in _____, state of _____, on the _____ day of _____, _____.

Signature of physician _____

