



Texas State Board of Dental Examiners

1801 Congress Avenue, Suite 8.600
Austin, Texas 78701-3942
(512) 463-6400 / Fax: (512) 649-1658

2x2 Passport Photo
Required

PLACE HERE

Dental Hygiene Faculty Member
Application

Instructions: Print legibly or type all information. All fields are required. Submitting an incomplete application will delay your application process. All supporting documentation should be submitted with this application. Fees are Non-Refundable. Make your check or money order payable to TSBDE and mail to the Texas State Board of Dental Examiners at 1801 Congress Avenue, Suite 8.600, Austin, TX 78701. A 2x2 passport photo is required.

Faculty License: \$125

Military Active Duty, Veteran, & Spouse: NO FEE:

Active Duty\*\* Veteran\*\* Active Duty Spouse\*\*

\*\* Please include a copy of one of the following: Copy of Military Orders, I.D. Card or proof of Honorable or General Discharge

Form with fields: Social Security #\*, Date of Birth (MM/DD/YYYY), Legal Last Name, Legal First Name, Legal Middle, Mailing Address, City, State, Zip, Daytime Phone #, Email Address, Employing School, City, Assigned Department

\* Pursuant to Sec. 59.001 of the Dental Practice Act, the social security number of an applicant for or holder of a license, certificate of registration, or other legal authorization issued by a licensing agency to practice in a specific occupation or profession that is provided to the licensing agency is confidential and not subject to disclosure under Chapter 552, Government Code.

Dental Education

Form with fields: Name of School, Degree Earned, Graduation Date (repeated twice), Jurisprudence Completion Date

State Licensure/Jurisdictions: List all state(s) and/or jurisdiction in which you have ever held a license. If you hold or have held a license in more than two states, please include the information on another sheet of paper submitted along with the application.

State: License Number Issue Date Disciplinary Action: Yes or No

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**Health Insurance**

Are you a Texas Medicaid Provider? \_\_\_\_ Yes \_\_\_\_ No

Are you a participating provider in the Texas Children’s Health Insurance Program (CHIP)? \_\_\_\_ Yes \_\_\_\_ No

**LICENSE HISTORY:** Please answer each of the following questions by putting a check (✓) in the appropriate box on the right. You must answer each question with a “Yes” or “No” response as no other response is acceptable. All “Yes” answers MUST be explained in detail in a separate SIGNED and NOTARIZED affidavit. The affidavit should include all relevant dates and identify the relevant jurisdiction and/or entity involved. Failure to disclose any of the requested information may result in the denial of your application or other appropriate action.

**NOTE:** If you answer “Yes” to any of the questions below and you have already submitted a detailed affidavit to this licensing authority explaining your response you need not submit another detailed affidavit. Please note the date of your previous submission next to the applicable question(s).

1. Have you ever had an application for a hygiene or any professional license, registration, certification, or permit refused or denied by any licensing authority or government agency?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
2. Have you ever had a hygiene or professional license, registration, certification, or permit revoked, suspended, or canceled by any license authority or government agency, or voluntarily surrendered?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
3. Have you ever been the subject of disciplinary action by any licensing authority or government agency with regard to a hygiene or any professional license, registration, certification, or permit?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
<b>If you answer “Yes” you must attach documentation of disciplinary action not previously reported to TSBDE.</b>		
4. For any criminal offense, including those pending appeal, have you ever: A. been convicted of a misdemeanor (other than minor traffic violations)? B. been convicted of a felony? C. pled nolo contendere, no contest, or guilty? D. received deferred adjudication? E. been placed on community supervision or court-ordered confinement? F. been sentenced to serve jail or prison time? court-ordered confinement? G. been granted pre-trial diversion? H. been arrested or have any pending criminal charges? I. been cited or charged with any violation of the law? J. been subject of a court-martial; Article 15 violation; or received any form of military judgement/punishment/action?  <b>If YES,</b> in addition to the affidavit, attach a certified copy of the court records regarding your conviction, the nature of the offense, date of discharge, if applicable. As well as a statement from the probation or parole officer. Also, provide a copy of an Order of Non-Disclosure or the Court Order expunging or sealing (non-disclosure) any conviction, offense, arrest, or citation.	YES <input type="checkbox"/>	NO <input type="checkbox"/>
5. Are you currently addicted to any chemical substance including alcohol (excluding tobacco and caffeine)?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
6. Are you currently abusing any chemical substance including alcohol (excluding tobacco and caffeine)?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
7. Have you ever been diagnosed with 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 as a Hygienist in a competent, ethical, and professional manner?	YES <input type="checkbox"/>	NO <input type="checkbox"/>

**TO BE COMPLETED BY DEAN, DEPARTMENT CHAIR, OR PROGRAM DIRECTOR**

I, \_\_\_\_\_, verify that the above-named applicant holds a:

Part Time                       Full Time

Salaried position with the following teaching institution: \_\_\_\_\_ and is a fit and proper issued faculty license to provide direct patient care with this institution or its adjunct facilities.

Signature of Dean, Department Chair, or Program Director:

Date:

**IN ADDITION TO THE FOREGOING:**

- A. I hereby give my permission for the Texas State Board Dental Examiners (TSBDE) to secure additional information or documentation concerning me or any of the statements in this application from any person or source the TSBDE may desire.
- B. I further agree to submit to questioning concerning my qualifications as an applicant by the TSBDE, staff, any member or agent thereof, and to substantiate my statements if desired by the TSBDE. I also agree to present all other credentials required or requested by the TSBDE.
- C. I, the applicant herein, 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 the Board in determining my qualifications whether it is called for or not. I agree that any falsification, omission, or withholding pertinent information or facts concerning my qualifications as an applicant shall be sufficient to bar me from licensure by the TSBDE and such falsification, omission or withholding shall serve as sufficient grounds for the revocation, cancellation, or suspension of my Texas license if not discovered until after issuance.

Signature of Applicant:

Date:

**STATE OF \_\_\_\_\_ COUNTY OF \_\_\_\_\_**

Before me, the undersigned authority, on this day personally appeared the applicant whose signature appears above and who being by me sworn upon oath says that all the facts, statements and answers contained in this application are true and correct.

Sworn and subscribed to before me, the said \_\_\_\_\_ appeared on this the \_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_\_, to certify which witness my hand and seal of office.

\_\_\_\_\_  
Notary Signature

(Seal)

## Faculty Dentist License Application Requirements Checklist

- Submit a fully completed application. Submitting an incomplete application will delay your application process.
- 1- 2x2 passport photo.
- Copy of driver's license, naturalization papers, or passport.
- Copy of current Basic Life Support CPR certification.
- Copy of a diploma from a dental school
- Endorsement from the Dean, Department Chair or Program Director of the employer-school verifying full-time or part-time salaried faculty position at a CODA-accredited dental school.
- Proof of completion of the Jurisprudence taken within one year immediately prior to application.
- National Practitioner Data Bank (NPDB) self-query report. Report results must remain in the original sealed envelope. NPDB reports are valid for 60 days. Contact NPDB at (800) 767-6732, or at <http://www.npdb.hrsa.gov/pract/howToGetStarted.jsp>.
- Military Active Duty, Veterans or Military Active Duty Spouses must provide either a copy of Military Change of Station Orders, Identification Card or a document showing proof of Honorable or General Discharge.
- For applicants who have held a license in another state/jurisdiction: A verification of licensure with imprint of state seal issued from a state board of dentistry in which the applicant has ever held a license to practice dentistry or dental hygiene. This is not a copy of your license. A copy of the license alone is not acceptable.

## Fingerprint Session

Once the Texas State Board of Dental Examiners is in receipt of your application, you will be notified via email of the agency's service code. This code is required in order for you to schedule a fingerprint session with IdentoGo.

## 2-Step Application and Payment process

Once TSBDE has approved your application, a license number will be issued. The status of your license will be expired with a future date. You will receive a letter of approval with instructions for activating your Initial renewal. The approval letter will authorize you to practice for 30 days. Once your initial renewal has been paid, you should receive your new license within 7-10 business days via mail.

**Exception:** Active duty military, veterans and active duty military spouses are not required to pay to activate their license. The license will be issued and mailed to the applicant after the application has been approved. Your first license may be valid anywhere between 6 months to 17 months. You will receive a reminder post card approximately 45 days prior to your license expiration date.

## Additional Information

Change of Address. Licensees are required to notify the TSBDE within 60 days of a change in address.

CPR Requirement. CPR Courses must include a hands-on demonstration of skills by the applicant on a manikin and a written assessment of skills.