

Board of Dentistry

P.O. Box 30670

Lansing, Michigan 48909

(517) 335-0918

www.michigan.gov/healthlicense**DENTAL SPECIALTY CERTIFICATION INSTRUCTIONS**

Authority: P.A. 368 of 1978, as amended
This form is for information only.

NOTE: It is your responsibility to have all required documentation sent to the Board of Dentistry. Questions regarding your application can be directed to the Michigan Board of Dentistry at (517) 335-0918 three weeks after the date you sent the application. Please allow 6-8 weeks processing time. Applications submitted without the required licensing fee, applicant's signature and date will be returned.

GENERAL INSTRUCTIONS

Please mark the appropriate type of licensure for which you are applying. Read all instructions carefully and answer all questions on the application. Please provide details on a separate sheet if necessary. Failure to correctly complete the application in its entirety may result in a delay in the processing of your application.

SPECIALTIES RECOGNIZED BY THE MICHIGAN BOARD OF DENTISTRY:

1. Oral (Maxillofacial) Surgery
2. Orthodontics
3. Prosthodontics
4. Periodontics
5. Pediatric Dentistry
6. Endodontics
7. Oral Pathology - No exam required.

REQUIREMENTS FOR ELIGIBILITY FOR SPECIALTY CERTIFICATION:

1. Must hold a current Michigan dental license.
2. **Effective October 1, 2008**, all applicants for a health profession license or registration in Michigan are required to submit fingerprints and undergo a criminal background check. Please see the attached instructions. The Michigan Board is not able to accept fingerprints that have been obtained for any other purpose. Your license or registration will not be issued until this process is complete.
3. Must have completed an ADA accredited graduate program in the specific specialty applied for and have the "Certification by Specialty Program Administrator" form and final, official transcripts submitted to this office directly by the hospital or school of dentistry providing the training.
4. Must file an application and fee with the Michigan Board of Dentistry for specialty certification.
5. Must have either, taken and passed the Michigan clinical and written specialty examination for your specialty or have American Board diplomate status in your specialty. Verification of diplomate status must be sent to this office directly from the appropriate agency.
6. All Michigan Specialty Examinations contain a minimum of two parts- Clinical and Written. If you have taken and passed the written portion of the American Board examination in your specialty, the Michigan written examination requirements may be waived. We must receive verification that you have passed the American Board written examination directly from the American Board.

Applicants made eligible to sit for the Michigan Specialty Examination will receive a brochure with specific instructions and requirements for the Specialty Examination.

7. If you are applying for certification by endorsement, complete PART I of the Certification for Licensure by Endorsement form and mail it to the state from which you are endorsing. PART II will be completed by that state. (The licensing agency of that state may charge a fee for this service. You may wish to contact them before you submit the form.)
8. If you have taken another state examination, please arrange to have that state's testing agency forward a copy of the examination specifications and your scores to the Michigan Board of Dentistry. The examination you took will be evaluated by the Michigan Board to see if it is equivalent to the Michigan Specialty examination. You will be notified by the Board's decision to accept either the examination you took or require that you pass all or part of the Michigan Specialty examination.
9. If you do not hold a current license in the state you are endorsing from, you must submit a Verification of Licensure form indicating possession of a current license in another state before you will be considered for licensure by endorsement in Michigan.
10. If you are or have been licensed in more than one state, complete the top portion of the Verification of Licensure form and forward it to all other states in which you are currently or have ever been licensed.

GENERAL INFORMATION

1. **NAME AND/OR ADDRESS CHANGES:** If your name and/or address changes please notify the Board of Dentistry in writing. To change a name or address, you can download the [Data Change/Duplicate License Request Form](#) from our website www.michigan.gov/healthlicense and fax it to (517) 373-2179 or mail the form to Bureau of Health Professions, Application Section, PO Box 30670, Lansing, MI 48909. Telephone calls are NOT accepted for these changes.
2. **REFUND POLICY:** If you wish to withdraw your application, you may be eligible for a partial refund. You must notify the Board of Dentistry in writing to request a refund.
3. **NOTE:** If you have ever been licensed in another state and you have a current disciplinary sanction on that license, (even if the license is inactive), you are **not** eligible for licensure in Michigan according to the Public Health Code, PA 368, as amended, Section 333.16174 (2). Sanctions include probation, limitation, suspension, revocation or fine. Upon resolution of the sanction and verification that the license is active with no disciplinary action in effect, you can proceed with the filing of an application for a Michigan license or registration.
4. **ORIGINAL LICENSES ARE VALID FOR ONE YEAR OR LESS; SUBSEQUENT RENEWALS ARE FOR A THREE-YEAR PERIOD.**



RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

STEVEN H HILFINGER
DIRECTOR

**CRIMINAL BACKGROUND CHECK
FINGERPRINT REQUEST FORM INSTRUCTIONS- (Michigan locations only)
AGENCY ID NUMBER IS 71734k**

Applicants for a Michigan health professional license may have their fingerprints taken by either L-1 Identity Solutions or Cogent Systems. Whether you use L-1 Identity Solutions or Cogent Systems, the Agency ID Number for health professional licensing is 71734k. This ID number MUST be used in order to have your fingerprint report sent to the Bureau of Health Professions. Keep the receipt you receive once your fingerprints are taken.

You must bring the Livescan Fingerprint Request Form (attached) and a driver's license or other state or federal-issued picture identification to your fingerprint appointment. You will also be required to pay a separate fee to the fingerprinting agency when registering for or scheduling your appointment.

When your fingerprints are taken, a technician will perform a scan of your fingerprints and submit the data electronically to the Michigan State Police. If no criminal history is found, the Bureau of Health Professions will be notified. If criminal history information is found, the Michigan State Police will send the record directly to the Bureau of Health Professions for review.

Information about fees and scheduling your fingerprint appointment with L-1 Identity Solutions can be found at www.L1enrollment.com or by calling 1-866-226-2952.

Information about fees and registering to have your fingerprints taken by Cogent Systems can be found at www.cogentid.com/index.htm. Click on Michigan and then select the Cogent MAPS (Michigan Applicant Processing Service) option. If you are using Cogent Systems, the MAPS option must be used for health professional licensing purposes. Cogent Systems can be reached by phone at 1-877-838-4903. E-mail inquiries about using Cogent Systems may be sent to mihelp@cogentsystems.com.



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GOVERNOR

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**CRIMINAL BACKGROUND CHECK
FINGERPRINT REQUEST FORM INSTRUCTIONS
(For applicants out of state or out of country)**

1. Contact a local law enforcement , governmental, or private fingerprinting agency to see if they can perform an ink fingerprint on an FBI (FD-258) card or on another state's official fingerprint card. The ink fingerprint must be completed on card stock.
2. Submit the card with your fingerprints, the completed Livescan Fingerprint Request Form (attached) and a business check or money order for \$62.75 made payable in U.S. Funds to L-1 Identity Solutions to the following address:

L-1 Enrollment Services/LiveScan Processing Unit
1650 Wabash Ave. Ste. D
Springfield, IL 62704

3. Please include a daytime telephone number or e-mail address where you can be reached if there are any questions.
4. L-1 Identity Solutions will submit your fingerprints to the Michigan State Police for analysis.
5. If no criminal history information is found, the Bureau of Health Professions will be notified.
6. If criminal history information is found, the Michigan State Police will send the record directly to the Bureau of Health Professions for review.
7. Call L-1 Identity Solutions toll-free at 1-866-226-2952 (8 am - 5 pm EST) if you have any questions.
8. L-1 Identity Solutions is under contract with the Michigan State Police (MSP) to provide fingerprint services. For questions, call MSP at (517) 241-0606.

LIVESCAN FINGERPRINT REQUEST FORM

Fingerprint Date:	TCN:
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Type of I.D. Presented:	Type of Licensure/Registration:
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Applicant Instructions: Take this completed form along with your picture I.D. to your scheduled appointment. Please print clearly.

First Name:	Middle Name:	Last Name:	
Street Address:			
City:	State:	ZIP Code:	
Daytime Telephone Number w/ Area Code:		State or Country of Birth:	
Date of Birth (MM/DD/YYYY):	Race:	Sex:	
Height:	Weight:	Eye Color:	Hair Color:

REQUESTING AGENCY INFORMATION

Agency I.D. Number: 71734k	Agency Name: Department of Licensing and Regulatory Affairs, Bureau of Health Professions
Reason Fingerprinted: LHP - Licensed Health Care Professional (MCL333.16174)	Cost:

****Disclaimer:** Any and all errors that result in dual fingerprinting (Duplicate transmission to MSP), multiple fingerprint codes, fingerprints processed with incorrect fingerprint codes/reasons, etc., are the responsibility of the **LIVESCAN AGENCY**. MSP will charge for dual fingerprinting (transmission), etc.

Board of Dentistry

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www.michigan.gov/healthlicense

APPLICATION FOR DENTAL SPECIALTY CERTIFICATION

Authority: Public Act 368 of 1978, as amended
if this form is not completed, a license will not be issued.

Type or Print Only

I AM APPLYING FOR SPECIALTY CERTIFICATION BASED ON THE FOLLOWING (Check One):

- Examination (Michigan Written and Clinical) Fee: \$345.00 71-2901-11
- Examination (Michigan Clinical Only) Fee: \$245.00 71-2901-28
- Prosthodontics, Pediatric, or Oral Pathology American Board Certification Fee: \$45.00 71-2901-11
- American Board Diplomate Status Fee: \$45.00 71-2901-11
- Endorsement Fee: \$45.00 71-2901-11
(Only those applicants who have been issued a license/certificate by another U.S. Jurisdiction in their specialty may apply for endorsement.)

Your check or money order drawn on a U.S. financial institution and made payable to the **STATE OF MICHIGAN** must accompany this application. **DO NOT SEND CASH.** Fees are deposited upon receipt and can only be refunded under refund rules promulgated by the Department.

I AM APPLYING FOR THE FOLLOWING SPECIALTY CERTIFICATIONS (A separate application must be submitted for each specialty.)

- Endodontics Oral and Maxillofacial Surgery Orthodontics Oral and Maxillofacial Pathology
- Pediatric Dentistry Periodontics Prosthodontics

Legal First Name	Legal Middle Name	Legal Last Name
U.S. Social Security Number	Date of Birth	Daytime Telephone Number ()
Street Address		E-mail Address
City	State	ZIP Code

All Previous Names and/or Birth Name Used (if applicable)

Have you ever held a health professional license in Michigan?
 No If yes, list Michigan permanent I.D./license number and expiration date: _____

Check the appropriate answer to each of the following questions. NOTE: Submit a detailed explanation for any YES answer you check on a separate sheet with your application.

1. Have you ever been convicted of a felony?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Have you ever been convicted of a misdemeanor punishable by imprisonment for a maximum term of 2 years?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Have you ever been convicted of a misdemeanor involving the illegal delivery, possession, or use of alcohol or a controlled substance (including motor vehicle violations)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Have you been treated for substance abuse in the past 2 years?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Have you had 3 or more malpractice settlements, awards, or judgments in any consecutive 5 year period?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Have you had one or more malpractice settlements, awards, or judgments totaling \$200,000 or more in any consecutive 5 year period?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Board Use Only

Specialty License Number: _____

Date of Licensure: _____

Name	
<p>7. Have you ever had a federal or state health professional license or certification revoked, suspended, or otherwise disciplined; been denied a specialty license; or currently have disciplinary action pending against you? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>8. Have you ever been censured, or requested to withdraw from a health care facility's staff or had your health care facility staff privileges involuntarily modified? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>9. Do you hold or have you ever held a dental specialty license or certification in any state? <input type="checkbox"/> Yes <input type="checkbox"/> No List each state, the license number, the date issued and how the license was obtained (either endorsement or examination). You must have each board verify licensure directly to this office. (Attach additional sheets, if necessary)</p>	

State	License Number	Date of Issue	How obtained (Endorsement or examination)

Provide a complete chronological record of your educational preparation. Attach additional sheets if necessary.

Name and Address of Institution	Dates of Attendance From To	Degree

Name of School Granting Specialty Degree or Certificate	Did you receive a (circle one)	Graduation Date
Name of Specialty	<input type="checkbox"/> Degree <input type="checkbox"/> Specialty Certificate	

Have you taken an American Board Examination in your specialty? Yes No Clinical Written

Date(s) of Examination(s) _____ Pass Fail
 _____ Pass Fail

Do you have American Board diplomate status in your specialty? Yes No

CERTIFICATION

I understand that it is the policy of this agency to secure a criminal conviction history as part of the pre-licensure screening process. I authorize this agency to use the information provided in this application to obtain a criminal conviction history file search from the Central Records Division of the Michigan Department of State Police or other law enforcement or judicial record-keeping organization.

I further consent to the release of information to this agency regarding any disciplinary investigations conducted by a similar licensure, registration, or specialty certification board of this or any other state, of the United States military, of the federal government, or of another country.

The statements in this application are true and correct. I have not withheld information that might affect the decision to be made on this application. In signing this application, I am aware that a false statement or dishonest answer may be grounds for denial of my application or revocation of my license and that such misrepresentation is punishable by law.

Signature of Applicant	Date
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CERTIFICATION OF SPECIALTY PROGRAM

Authority: Public Act 368 of 1978, as amended
 If this form is not completed, a certification will not be issued.

SECTION I - APPLICANT INFORMATION

Instructions: Applicant complete Section I. Type or print your name exactly as it appears on your application. Send this form to the Program Administrator for your specialty program for completion of Section II and then have the Administrator send it directly to the Board.

First Name	Middle Name	Last Name
Social Security Number		Date of Birth
Street Address		E-mail Address:
City	State	ZIP Code
Daytime Telephone Number	All Previous Names and/or Birth Name Used (if applicable)	

SECTION II - CERTIFICATION OF SPECIALTY PROGRAM - Instructions: Administrator complete Section II and return it directly to the Michigan Board of Dentistry at the address given above.

NOTE: This certification may not be dated and submitted more than fifteen (15) days prior to the completion of the specialty program.

Name of Hospital or School
Street Address of Hospital or School
City, State and ZIP Code

I certify that _____ completed all requirements at
 Applicant's Name

_____ for a _____
 Name of Hospital or School of Dentistry Name of Specialty

Degree Certificate on _____
 Month\Date\Year

 Signature of Program Administrator

 Date of Signature

 Print or Type Name and Title of Program Administrator

(Seal of School or Hospital)

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CERTIFICATION OF COMPLETION FOR EXAM ELIGIBILITY

Authority: Public Act 368 of 1978, as amended
 If this form is not completed, a certification will not be issued.

SECTION I - APPLICANT INFORMATION

Instructions: Applicant complete Section I. Type or print your name exactly as it appears on your application. Send this form to the Program Administrator for your specialty program for completion of Section II and then have the Administrator send it directly to the Board.

First Name	Middle Name	Last Name
Social Security Number	Date of Birth	
Street Address	E-mail Address:	
City	State	ZIP Code
Daytime Telephone Number	All Previous Names and/or Birth Name Used (if applicable)	

EXAM ELIGIBILITY: To be eligible for the Michigan Specialty examination the applicant must be scheduled to graduate no more than 90 days from the exam date.

Name of Hospital or School
Street Address of Hospital or School
City, State and ZIP Code

I certify that _____ is scheduled to complete the
 Applicant's Name

required specialty program at _____ on _____
 Name of Hospital or School of Dentistry Month\Date\Year

 Signature of Program Administrator

 Date of Signature

 Print or Type Name and Title of Program Administrator

(Seal of School or Hospital)

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CERTIFICATION FOR SPECIALTY CERTIFICATION BY ENDORSEMENT

Authority: Public Act 368 of 1978, as amended.

If this form is not completed, certification will not be issued if applying by endorsement.

PART I: To be completed by applicant and forwarded to the licensing agency of the state from which you are endorsing.

First Name	Middle Name	Last Name
U.S. Social Security Number	Date of Birth	
Street Address		
City	State	ZIP Code
Daytime Telephone Number	Previous Name Used (If Applicable)	

Type of Specialty	License/Certification Number	
Specialty School Attended	Graduation Date	
Street Address		
City	State	ZIP Code

PART II: To be completed by the licensing agency of the state from which you are endorsing your specialty license/certificate.

The applicant listed above has applied for specialty certification in Michigan based, in part, on his/her licensure/certification in your state. Please complete Part II of this form to assist us in processing his/her application and return it directly to the Michigan Board of Dentistry at the address above.

1. Which Do You Issue? (Check One): SPECIALTY LICENSE SPECIALTY CERTIFICATION

Name of Licensed/Certified Specialist

License/Certificate Number

Date Issued

2. Indicate the licensure requirements that were in effect at the time applicant was licensed/certified in your state. (Respond yes or no and elaborate if necessary.)

a. Degree: _____

b. Accredited School: _____

c. Specialty Exam: Regional _____ State Constructed _____

d. Other (Explain): _____

The Department of Licensing and Regulatory Affairs will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability or political beliefs. If you need assistance with reading, writing, hearing, etc., under the American Disabilities Act, you may make your needs known to this agency.

Name

"SCORE" MEANS A NUMBER, PERCENT, OR PASS/FAIL. PLEASE GIVE AS MUCH INFORMATION REGARDING THIS EXAMINATION AS POSSIBLE.

3. SPECIALTY WRITTEN/COMPREHENSIVE EXAMINATION

EXAMINATION SUBJECT	SCORE

4. SPECIALTY CLINICAL EXERCISE EXAMINATION

EXAMINATION SUBJECT	SCORE

5. Please describe the passing score rule that was in effect at the time the above exam was taken. _____

6. Please describe the criteria used to determine the passing level. _____

7. Specialty Status: Current Lapsed Inactive Expiration Date: _____

8. Has the applicant ever had a license revoked, suspended, or otherwise disciplined; been denied a license; or currently have a disciplinary action pending? If yes, please attach certified copies of any action(s). Yes No

Signature

State Board

Printed or Typed Name

Date

Title

Michigan Department of Licensing and Regulatory Affairs

Bureau of Health Professions

P.O. Box 30670

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VERIFICATION OF LICENSURE OR REGISTRATION IN ANOTHER STATE

Authority: Public Act 368 of 1978, as amended.

PART I: To be completed by the applicant and forwarded to the appropriate State Licensing Board for completion.

Check the profession for which you are requesting verification.		
<input type="checkbox"/> Acupuncture	<input type="checkbox"/> Medicine	<input type="checkbox"/> Pharmacy
<input type="checkbox"/> Audiology	<input type="checkbox"/> Nursing	<input type="checkbox"/> Physical Therapy
<input type="checkbox"/> Chiropractic	<input type="checkbox"/> Nursing Home Admin.	<input type="checkbox"/> Physician's Assistants
<input type="checkbox"/> Counseling	<input type="checkbox"/> Occupational Therapy	<input type="checkbox"/> Podiatry
<input type="checkbox"/> Dentistry	<input type="checkbox"/> Optometry	<input type="checkbox"/> Psychology
<input type="checkbox"/> Marriage & Family Therapy	<input type="checkbox"/> Osteopathy	<input type="checkbox"/> Respiratory Therapy
<input type="checkbox"/> Sanitarian	<input type="checkbox"/> Social Work	<input type="checkbox"/> Veterinary Medicine
First Name	Middle Name	Last Name
Previous Names Used	Date of Birth	U. S. Social Security Number
State Board	License Number	Date of Issue

The applicant listed above has applied for licensure in Michigan and has indicated licensure in your State. Please complete Part II of this form and return it to the appropriate Michigan Board at the address shown above.

PART II: To be completed by the State Licensing Board.

Type of License:	Original Issue Date	Expiration Date
Basis for Issuance of License:		
<input type="checkbox"/> Examination - Please indicate type of exam (National, Regional, State, etc.) _____		
<input type="checkbox"/> Endorsement - Please indicate name of state _____		
License Status	Has the applicant incurred any formal or informal actions in your State?	
<input type="checkbox"/> Current <input type="checkbox"/> Lapsed <input type="checkbox"/> Inactive	<input type="checkbox"/> No <input type="checkbox"/> Yes - If Yes, Please attach certified copies of any actions.	
Are formal or informal actions pending?	Has the applicant's license ever been limited, denied, surrendered, reprimanded, suspended or revoked?	
<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	

CERTIFICATION

I hereby verify, to the best of my knowledge, the information above is true to the records of this Board.

Signature_____
Date_____
Type or Print Name

(S E A L)

Title_____
Full Name of Licensing Board