Date	Fee	Licensed In	NPDB	License No.	Issue Date

FOR KBD USE ONLY

Form AFC0124
Rev. Jan. 2024

Kentucky Board of Dentistry

312 Whittington Parkway, Ste. 101, Louisville, KY 40222
(p) 502-429-7280 | (f) 502-429-7282 | kbd@ky.gov | dentistry. ky.gov

APPLICATION FOR CHARITABLE LIMITED LICENSURE

Please print in ink or type your responses and return this notarized application, all supporting documents, and $25 application fee (check or money order made out to Kentucky Board of Dentistry) to the address above. If necessary, attach a separate sheet of paper to fully answer all of the following questions. Applications should be received at least 30 days prior to the charitable event identified below.

Charitable Event: Name _____ Sponsor _____ Date(s) _____

Name: Last/Suffix _____ First _____ Middle _____

Former Name _____ Date of Birth _____ Citizen of _____

SS# _____ Home/Cell Phone _____ Business Phone _____

Email _____ Business Name _____

Business Address _____

Home Address _____

Preferred Mailing Address ◯ Business ◯ Home Gender ◯ M ◯ F Applying for ◯ Dental License ◯ Dental Hygiene License

Provide School Name, Location, and Degree Earned for All Dental Education _____

_____

Provide State and License No. for All Active Licenses _____

Please affirm all TRUE statements below and attach a written explanation for any FALSE statements:

1. I have actively practiced dentistry/dental hygiene for at least five of the last six years. ◯ True ◯ False
2. I have never had my license or prescribing authority denied, revoked, restricted or disciplined. ◯ True ◯ False
3. I have have not surrendered or failed to renew a dentist/hygienist license while under investigation. ◯ True ◯ False
4. I have not ever been convicted of a misdemeanor or felony. ◯ True ◯ False
5. I have not been sued for malpractice, professional negligence, or insurance code violations. ◯ True ◯ False

Notarized affidavit to be signed in the presence of a notary

I, the undersigned, hereby certify under penalty of law that I am the person referred to in this application, that the attached photograph is of myself, and that the information provided herein is accurate and complete to the best of my knowledge. I further attest that I understand and agree to abide by the statutes, rules, and regulations governing charitable practice in Kentucky as provided for in KRS 313.254 and 201 KAR 8:533, 563 and 581. I will work only with registered charitable entities and do so without expectation of compensation. I will not write prescriptions and will only perform procedures that can be completed in the duration of the charitable event.

Attach a head and shoulders photograph taken within the past six months.

No hats, please.

Applicant Signature _____ Date _____

For Use by Notary Public

State of _____ County of _____

Signed and sworn before me this _____ day of _____, _____

Notary Seal

Signature _____ Commission Expires _____

Kentucky Board of Dentistry

312 Whittington Parkway, Ste. 101, Louisville, KY 40222
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APPLICATION FOR RENEWAL OF DENTAL LICENSURE

Pursuant to KRS 313.030, dental licenses in Kentucky expire on Dec. 31 of odd-numbered years and must be renewed in order to remain active. Please print in ink or type your responses, using your name as it appears on your dental license. Return this completed application and renewal fee of $295 (add $50 if renewing a specialty license) with a check or money order made out to the Kentucky Board of Dentistry to the address above. Once your application is processed, you will be notified of your successful license renewal.

Name: Last/Suffix _____ First _____ Middle _____

License # _____ Phone _____ Email _____

Home Address _____

Business Address _____

Preferred Mailing Address: ◯ Home *or* ◯ Business Indicate any fields above that changed since last renewal _____

If also renewing a specialty license, please indicate the type of specialty _____

The licensee shall meet the eligibility criteria* for license renewal and attest to the following:

Initial

_____ I have actively practiced dentistry in the previous two years.

_____ I have maintained my CPR certification which meets or exceeds the American Heart Association guidelines.

_____ I have completed all CE requirements to renew my license and, if applicable, any sedation permit(s) I may hold.

_____ I have not had a dental license denied, revoked, suspended or disciplined by another state or territory.

_____ I have not been convicted of, pled guilty to, or entered an Alford plea for a felony or misdemeanor since my last renewal.

**If you do not meet the above criteria, are unsure of your renewal eligibility, or have other questions, please contact the Board of Dentistry office.*

I, the undersigned, hereby certify under penalty of law that I am the person referred to in this application and that the information provided herein is accurate and complete to the best of my knowledge. I acknowledge that the submission of false or fraudulent information as part of this application is grounds for disciplinary and/or legal action. I further attest that I understand and agree to abide by the statutes, rules, and regulations governing dentistry in Kentucky.

Applicant's Signature _____ Date _____

Date	Juris.	CPR	Verification	NPDB	Backgrnd
Fee	Boards	Clinical	Transcript	License No.	Issue Date

FOR KBD USE ONLY

Form AFD0124
Rev. Jan. 2024

Kentucky Board of Dentistry

312 Whittington Parkway, Ste. 101, Louisville, KY 40222
(p) 502-429-7280 | (f) 502-429-7282 | kbd@ky.gov | dentistry. ky.gov

APPLICATION FOR DENTAL LICENSURE

Please print in ink or type your responses and return this notarized application, all supporting documents, and application fee (check or money order made out to Kentucky Board of Dentistry) of $325 if applying in an even numbered year or $175 if an odd numbered year to the address above. If necessary, attach an additional sheet to fully answer all of the following questions.

Name: Last/Suffix _____ First _____ Middle _____

Former Name(s) _____ SS# _____ Gender (M/F) _____

Citizen of _____ If naturalized U.S. citizen, give date and place _____

Date of Birth _____ Place of Birth _____ Preferred Mailing Address ◯ Home ◯ Business

Home Address _____

Home/Cell Phone _____ Email _____

Intended Business Address _____

Business Name _____ Business Phone _____

Applying for ◯ Licensure by Exam ◯ Licensure by Credentials ◯ Licensure by Foreign Training ◯ Student Limited License ◯ Faculty Limited License

Clinical Exam Completed _____ Date _____ Location _____

Identify the successful completion of all CODA accredited graduate or postgraduate programs below. Documentation of program completion should accompany this application.

School/Program	*Location*	*Degree*	*Dates Attended*

Identify all states or other licensing jurisdictions where you have held or currently hold a dental license.

State	*License #*	*State*	*License #*

Identify all places of practice since graduation, beginning with the most recent.

Business Name & Address	*Dates*

Please affirm all TRUE statements below and attach a written explanation for any FALSE statements:

1. I am a graduate of a CODA accredited DMD/DDS program or post-graduate general dentistry program?	○ True	○ False
2. I understand, read, speak, and write English with a least a ninth grade (Level 4) comprehension.	○ True	○ False
3. I have successfully completed the National Board written exam.	○ True	○ False
4. I have successfully completed a qualifying clinical exam within three attempts.	○ True	○ False
5. I have never had a dental license or DEA permit denied, revoked, restricted or disciplined.	○ True	○ False
6. I have never been suspended, sanctioned, or restricted from a private or public insurance program.	○ True	○ False
7. I have have not surrendered or failed to renew a dental license while under investigation.	○ True	○
8. I do not have disciplinary action pending against my dental license, DEA permit, or insurance participation.	○ True	○
9. I have never been convicted of a misdemeanor or felony.	○ True	○ False
10. I have not been sued for malpractice, negligence, or professional misconduct.	○ True	○ False

Notarized affidavit to be signed in the presence of a notary

I, the undersigned, hereby certify under penalty of law that I am the person referred to in this application, that the attached photograph is of myself, and that the information provided herein is accurate and complete to the best of my knowledge. I authorize the Kentucky Board of Dentistry or its agents to obtain from other sources any information necessary to confirm my qualifications. I understand that the submission of false or fraudulent information as part of this application is grounds for disciplinary and/or legal action. I further attest that I understand and agree to abide by the statutes and regulations governing dentistry in Kentucky as codified in KRS 313 and 201 KAR 8.

Attach a head and shoulders photograph taken within the past six months.

No hats, please.

Applicant Signature _____ Date _____

_____ For Use by Notary Public _____

State of _____ County of _____

Signed and sworn before me this _____ day of _____, _____

Notary Seal

Signature _____ Commission Expires _____

TEAM KENTUCKY

Date	Fee	Bkrgnd	NPDB	CPR	Verif.	Issue Date

FOR KBD USE ONLY

Form ATR0124
Rev. Jan. 2024

Kentucky Board of Dentistry

312 Whittington Parkway, Ste. 101, Louisville, KY 40222
(p) 502-429-7280 | (f) 502-429-7282 | kbd@ky.gov | dentistry. ky.gov

APPLICATION TO REINSTATE DENTAL OR DENTAL HYGIENE LICENSURE

Please print in ink or type your responses, using your name as it appears on your dental license. Return this notarized application, supporting documents, and application fee (check or money order made out to Kentucky Board of Dentistry) to the address above. The dentist fee is $325 if applying in an even numbered year or $175 if an odd numbered year. For hygienists, the fee is $75 (even year) and $125 (odd year).

Name: Last/Suffix _____ First _____ Middle _____

Former Name _____ Date of Birth _____ SS # _____

Former License # _____ Home/Cell Phone _____ Business Phone _____

Email _____ Applying for reinstatement of: ◯ Dentist License ◯ Dental Hygienist License

Preferred Mailing Address: ◯ Home ◯ Business Intended Business Name _____

Business Address _____

Home Address _____

States (include license #) practiced in since licensed in KY _____

Please affirm all TRUE statements below and attach a written explanation for any FALSE statements:

1. I have actively practiced dentistry/dental hygiene within the last two years. ◯ True ◯ False
2. I have never had my license or prescribing authority denied, revoked, restricted or disciplined. ◯ True ◯ False
3. I have have not surrendered or failed to renew a dentist/hygienist license while under investigation. ◯ True ◯ False
4. I have not ever been convicted of a misdemeanor or felony. ◯ True ◯ False
5. I have not been sued for malpractice, professional negligence, or insurance code violations. ◯ True ◯ False

Notarized affidavit to be signed in the presence of a notary

I, the undersigned, hereby certify under penalty of law that I am the person referred to in this application, that the attached photograph is of myself, and that the information provided herein is accurate and complete to the best of my knowledge. I authorize the Kentucky Board of Dentistry or its agents to obtain from other sources any information necessary to confirm my qualifications. I understand that the submission of false or fraudulent information as part of this application is grounds for disciplinary and/or legal action. I further attest that I understand and agree to abide by the statutes, rules, and regulations governing dentistry in Kentucky.

Attach a head and shoulders photograph taken within the past six months.

No hats, please.

Applicant Signature _____ Date _____

For Use by Notary Public

State of _____ County of _____

Signed and sworn before me this _____ day of _____, _____

Notary Seal

Signature _____ Commission Expires _____

Date	Fee	CODA Prgm	License No.	Issue Date

Form AFS0124
Rev. Jan. 2024

FOR KBD USE ONLY

Kentucky Board of Dentistry

312 Whittington Parkway, Ste. 101, Louisville, KY 40222
(p) 502-429-7280 | (f) 502-429-7282 | kbd@ky.gov | dentistry. ky.gov

APPLICATION FOR SPECIALTY DENTAL LICENSURE

Pursuant to 201 KAR 8:533, dentists with the appropriate training may apply for specialty licensure. Please print in ink or type your responses, using your name as it appears on your existing license. Return this completed and notarized application, supporting documents, and application fee of $100 (check or money order made out to the Kentucky Board of Dentistry) to the address above.

Name: Last/Suffix _____ First _____ Middle _____

License # _____ Phone _____ Email _____

Applying for Specialty in (select one): ◯ Orthodontics ◯ Endodontics ◯ Oral & Maxillofacial Surgery ◯ Pediatric Dentistry

◯ Prosthodontics ◯ Periodontics ◯ Other _____ *(All NCRDSCB recognized specialties accepted)*

Identify the successful completion of any CODA accredited graduate or postgraduate specialty programs below. Documentation of program completion should accompany this application.

School/Program	*Location*	*Degree*	*Dates Attended*

Notarized affidavit to be signed in the presence of a notary

I, the undersigned, hereby certify under penalty of law that I am the person referred to in this application, that the attached photograph is of myself, and that the information provided herein is accurate and complete to the best of my knowledge. I authorize the Kentucky Board of Dentistry or its agents to obtain from other sources any information necessary to confirm my qualifications. I understand that the submission of false or fraudulent information as part of this application is grounds for disciplinary and/or legal action. I further attest that I understand and agree to abide by the statutes, rules, and regulations governing specialty dentistry in Kentucky.

Attach a head and shoulders photograph taken within the past six months.

No hats, please.

Applicant Signature _____ Date _____

For Use by Notary Public

State of _____ County of _____

Signed and sworn before me this _____ day of _____, _____

Notary Seal

Signature _____ Commission Expires _____

TEAM KENTUCKY

Kentucky Board of Dentistry

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DUPLICATE LICENSE OR REGISTRATION REQUEST FORM

Please print in ink or type your responses. Submit this completed application to the Board of Dentistry via mail, fax or email using the contact information above.

Name: Last/Suffix _____ First _____ Middle _____

License/Reg. # _____ Phone _____ Email _____

Requesting Duplicate of:
- ◯ Dentist License
- ☐ Dental Hygienist License*
- ☐ Dental Assistant Registration
- ☐ Dental Lab Registration
- ☐ Sedation/Anesthesia Permit
- ☐ Sedation Facility Certificate

**Any special registrations held by a dental hygienist (general supervision, public health hygiene, local anesthesia, laser debridemet, IV access lines) will be indicated on their license.*

Please send:
- ☐ Framing Style
- ☐ Renewal Style

Send via:
- ☐ Email (renewal style only)
- ☐ Mail (provide mailing address below)

_____

_____

TEAM KENTUCKY

Kentucky Board of Dentistry
312 Whittington Parkway, Ste. 101, Louisville, KY 40222
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RETIREMENT OF LICENSE FORM

Please print in ink or type your responses, using your name as it appears on your license. Use the contact information above to mail, fax, or email this form. Once received and processed, the Board shall send confirmation of license retirement.

Name: Last/Suffix _____ First _____ Middle _____

Home Address _____

Home/Cell Phone _____ Email _____

License Type: ◯ Dentist ◯ Dental Hygienist License # _____ Effective Date of Retirement _____ / _____ / _____

I, the undersigned, hereby certify under penalty of law that I am the person referred to in this form and that the information provided herein is accurate and complete to the best of my knowledge. I agree not practice in Kentucky after the effective date listed above. I understand that my license shall not be properly retired if there is pending disciplinary action against it. Further, I acknowledge that if I intend to reinstate my license in the future, I must meet the requirements as set forth in Kentucky's statutes and regulations.

Signature _____ Date _____

Kentucky Board of Dentistry
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STATEMENT REGARDING FACULTY LICENSURE LIMITATIONS

In accordance with 201 KAR 8:533, I understand that upon receipt of a Faculty Limited License issued by the Board of Dentistry, I will be authorized to practice dentistry only in conjunction with programs of the dental school where I am a faculty member and that I may only provide professional services to patients of these programs.

I further acknowledge that I am solely responsible for the requirements of maintaining and renewing my Faculty Limited License as required by law.

Name _____ University _____

Signature _____ Date _____

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STATEMENT REGARDING STUDENT LICENSURE LIMITATIONS

In accordance with 201 KAR 8:533, I understand that upon receipt of a Student Limited License issued by the Board of Dentistry, I will be authorized to practice dentistry only in conjunction with the postgraduate, residency, or fellowship programs of the dental school where I am enrolled and that I may only provide professional services to patients of these programs.

I further acknowledge that I am solely responsible for the requirements of maintaining and renewing my Student Limited License as required by law.

Name _____ University _____

Program Name _____ Expected Completion Date _____

Signature _____ Date _____

Form VOL0124
Rev. Jan. 2024

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312 Whittington Parkway, Ste. 101, Louisville, KY 40222
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VERIFICATION OF LICENSURE OR REGISTRATION FORM

Please print in ink or type your responses. Return this application and a $40 application fee (check or money order made out to Kentucky Board of Dentistry) to the address above. Board policy is to send official verification of any licenses or registrations currently or previously held by the applicant via certified mail directly to the regulatory entity, not to the applicant.

Verification letters arrive with the Board of Dentistry seal affixed and contain the following fields for dentists and dental hygienists: Name, License Number, Issue Date, License Type, Expiration Date, Current Status, Licensure Method, School Attended, Graduation Year, and Disciplinary Actions. Verification of dental assistant registration will have more limited information.

Licensee or Registrant Information

Name: Last/Suffix _____ First _____ Middle _____

Phone _____ Email _____

License# _____ Type: ◯ Dentist ◯ Dental Hygienist ◯ Dental Assistant ◯ Other _____

Recipient Information (Verification will be sent directly to this address)

Organization _____ Attn _____

Address _____ City, State, Zip _____

Phone _____ Email _____

Additional Information (Include any important details or special instructions)

_____

_____

Signature _____ Date _____

TEAM KENTUCKY