



## APPLICATION FOR DENTAL REINSTATEMENT

**GEORGIA BOARD OF DENTISTRY**  
237 Coliseum Drive  
Macon, Georgia 31217  
Phone (478) 207-2440  
Fax (866) 888-1308  
[www.sos.ga.gov/plb/dentistry](http://www.sos.ga.gov/plb/dentistry)

Please read the instructions carefully and be familiar with the laws and rules governing the practice of dentistry in the State of Georgia. Visit the board's web site for information: <http://www.sos.ga.gov/plb/dentistry>

### **\*\*Important\*\***

**The Board cannot process incomplete applications. If any item is missing, incomplete or incorrect, your application cannot be reviewed by the Board.**

**Please review this application before you submit it to ensure that all information and documentation is complete and correct.**

**Incomplete applications result in delayed processing and are void after one year.**

**\*\*\*NOTE – IF YOU ARE PRACTICING IN GEORGIA & YOUR LICENSE HAS EXPIRED – YOU CANNOT CONTINUE TO PRACTICE UNTIL YOUR LICENSE HAS BEEN REINSTATED – YOU MUST IMMEDIATELY CEASE & DESIST PRACTICE.\*\*\***

### Application Checklist

The following checklist is an important part of your application. Please use this checklist to ensure that you submit a COMPLETE application.

The **non-refundable** application fee is \$750 for dentists, \$350 for hygienists. Please tender payment made payable to the **Georgia Board of Dentistry**. The fee must be included you're you application.

1. **Completed application form** accompanied by the appropriate fee. If reinstatement is granted, the licensee will be required to renew by the last day of December in ODD numbered years, regardless of when you were reinstated.
2. **Official license verification** from **every** dental/dental hygiene license **ever** held. Each verification must indicate the date of licensure, the licensure status (active, inactive, expired, revoked, etc.) standing of license, any disciplinary charges made against you by the licensing board and the result

of these actions. The applicant must provide a copy of the formal complaint/pleading, outcomes, and a personal written explanation for each instance of discipline. You should call each state board about fees for these services. The letter(s) must be submitted with your application **IN THE ORIGINAL SEALED ENVELOPE FROM THE STATE BOARD**, and must be dated within four months of Board receipt of your complete application packet.

3. **Jurisprudence Examination:** The examination must be downloaded from our website. The study materials are also on our website. The fee for this examination is \$25.00, payable to the order of Georgia Board of Dentistry. FEES ARE NON REFUNDABLE. *A score of 75 or higher is considered a passing score.*
4. **National Practitioner Databank:** To obtain a self query from the NPDB-HIPDB, please visit [www.npdb-hipdb.com](http://www.npdb-hipdb.com) or call the Customer Service Center at 1-800-767-6732.

**If the National Practitioner Data Bank(NPDB)** provides any disciplinary action, certified copies of any pending or final disciplinary actions or malpractice actions against applicant must be submitted. All applicants must submit a NPDB report along with the completed application. The NPDB report must be dated within four months of the submission of the application. *“The ONLY applicants exempt from the requirement of NPDB report submission are those applicants within 6 months of dental school graduation and who have never been issued a dental license in any state or U.S. territory”.*

The NPDB report must be received in the ORIGINAL SEALED ENVELOPE FROM NPDB. Applicants who have disciplinary or malpractice case(s) (open & closed) will be considered for licensure on a case- by-case basis, after receipt of all required application materials. For each case, the applicant must submit:

- 1) a copy of the formal complaint pleadings filed by the plaintiff/complainant or State Regulatory Agency,
- 2) a copy of the final action, disposition, or settlement,
- 3) a personal explanation of the disciplinary action or the malpractice claim, and
- 4) any further information requested by the Board in separate communications.

5. **Copy** of current CPR card
6. **Resume or Curriculum Vitae** – List chronologically all employment, hospital privileges, specialty training and all other experience in the practice of dentistry/dental hygiene. Include names, beginning and ending dates, and locations, where applicable. Explain any intervals where you were not in training or practicing dentistry/dental hygiene.
7. **Four (4) References** (forms attached) - The reference forms must be mailed in with the application **IN THE ORIGINAL SEALED ENVELOPE FROM THE REFERENCE.**
8. **Continuing Education** - All licensees are required to have continuing education credits in order to maintain a license in the State of Georgia.
  - o **Dentists** must submit proof of 40 hours of Board approved continuing education obtained within the last two (2) years from the date of submission of application for Board approval.

- **Hygienists** must submit proof of 22 hours of Board approved continuing education obtained within the last two (2) years from the of submission of application for Board approval. (Submit photocopies only- original certificates will not be returned)

**Note:** An additional 40 hours for dentists and 22 hours for hygienists must be obtained for the upcoming renewal period. The hours submitted for reinstatement of license cannot be used to fulfill the requirements for an upcoming license renewal period.

9. **Malpractice Questionnaire** - Be sure to complete one for each suit and attach the necessary documentation. (If not applicable, write N/A on the form sign, date, and return with application).
10. **Relocation** - If you relocate during the time that your application is being processed, you **must** notify the Board of your new address in writing by fax (478) 314-9152 or mail. This will enable you to receive Board correspondence.

Reminder: It is against the law to practice dentistry/dental hygiene with a lapsed/expired license. An individual who continues to practice with a lapsed/expired license is subject to a fine and disciplinary action.

In accordance with Rule 150-3-.05, as a condition precedent to reinstatement after five (5) years have passed without the applicant being actively engaged in the practice of dentistry or dental hygiene, the Board may, in its discretion, require passage of an examination administered by the Georgia Board of Dentistry or a Regional Testing Agency designated and approved by the Board. In addition, the Board may require documentation from a physician or physicians licensed in the State of Georgia that establishes to the satisfaction of the Board that the applicant is able to practice with reasonable skill and safety to patients.

**\*\*\*NOTE – IF YOU ARE PRACTING IN GEORGIA & YOUR LICENSE HAS EXPIRED – YOU CANNOT CONTINUE TO PRACTICE UNTIL YOUR LICENSE HAS BEEN REINSTATED – YOU MUST IMMEDIATELY CEASE & DESIST PRACTICE.\*\*\***

FOR BOARD USE ONLY  
 Amount Submitted \_\_\_\_\_  
 Date \_\_\_\_\_  
 Receipt # \_\_\_\_\_



FOR BOARD USE ONLY  
 Certificate Number \_\_\_\_\_  
 Date Issued \_\_\_\_\_  
 Applicant No. \_\_\_\_\_

**GEORGIA BOARD OF DENTISTRY**

237 Coliseum Drive • Macon, Georgia 31217 • (478) 207-2440  
[www.sos.ga.gov/plb/dentistry](http://www.sos.ga.gov/plb/dentistry)

**APPLICATION FOR DENTAL/DENTAL HYGIENE REINSTATEMENT**

**Application Fee \$ 750 Dentist \$350 Hygienist (non-refundable)**

**License Type:** \_\_\_\_\_ Dentist  
 \_\_\_\_\_ Dental Hygienist

**Method Obtained by:**

Applicant is applying for above referenced license by: Application

**Name** as desired on License

\_\_\_\_\_ First Middle Last

Name as shown on exam records or transcripts  
 (if different)

\_\_\_\_\_ First Middle Last

\_\_\_\_\_ **Social Security Number**

\_\_\_\_\_ **Date of Birth**

\_\_\_\_\_ **e-mail address**

**Physical Address**

\_\_\_\_\_ Number and Street Apt. No City/State  
 Zip

***P.O. Box not acceptable***

**Mailing Address**

(if different) \_\_\_\_\_ Number and Street Apt. No City/State Zip

\_\_\_\_\_ Telephone Number Day

\_\_\_\_\_ Telephone Number Evening

**LAPSED/EXPIRED LICENSE NUMBER:** \_\_\_\_\_

1. Date last renewed: \_\_\_\_\_ State reason license not renewed: \_\_\_\_\_

2. Have you practiced as a dentist or dental hygienist in the State of Georgia since your license expired on?

\_\_\_\_\_ YES \_\_\_\_\_ NO **\*\*\*NOTE – IF YOU ARE PRACTING IN GEORGIA & YOUR LICENSE HAS EXPIRED – YOU CANNOT CONTINUE TO PRACTICE UNTIL YOUR LICENSE HAS BEEN REINSTATED – YOU MUST IMMEDIATELY CEASE & DESIST PRACTICE.\*\*\***

3. If you are now or have ever been licensed to practice dentistry/dental hygiene in another state or country, you are required to complete the following information in chronological order:

State/Country	Date of Licensure	License Granted by EXAM or RECIP.	Status of Licensure (current, inactive, etc.)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

4. If you are a dentist, are you Board trained or Board certified? \_\_\_\_ YES \_\_\_\_ NO. If Yes, send copy of certificate. ( Only applies to dentists)

5. Do you intend to practice dentistry/dental hygiene in Georgia? \_\_\_\_ YES \_\_\_\_ NO If YES, in what specialty? \_\_\_\_\_

6. Have you served in the Armed Forces of the U.S.? \_\_\_\_ YES \_\_\_\_ NO. If so, list dates \_\_\_\_\_ Discharge date \_\_\_\_\_ Type of discharge \_\_\_\_\_ If other than honorable, furnish complete details.

**If you answer "YES" to any of the following questions, you are required to furnish complete details, including date, place and reason, and disposition of the matter.**

- |                                                                                                                                       | YES                      | NO                       |
|---------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|
| 7. Have you ever been treated or hospitalized for drug or alcohol abuse?                                                              | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Have you ever been convicted of a violation of any Federal, State or Local Statute?                                                | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Have you ever been denied the privilege of taking an examination given by any state board or been denied a certificate of license? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Has any state licensing board revoked or suspended your certificate/license, or taken other disciplinary action?                  | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Have you ever had your hospital privileges limited, denied or revoked?                                                            | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Have you ever been denied a DEA registration number or been issued a restricted DEA registration?                                 | <input type="checkbox"/> | <input type="checkbox"/> |
| If currently registered, give number and state of issue.<br>Number _____ State _____                                                  | <input type="checkbox"/> | <input type="checkbox"/> |

13. Have you ever had any malpractice suits filed against you?
14. Have you ever been denied membership in any dental/dental hygiene association or society, or specialty society?
15. Have you ever resigned from a hospital staff after a complaint or peer review action has been initiated against you?
16. Have you ever voluntarily surrendered a dental license, a controlled substances registration or DEA registration?
17. To your knowledge, are you the subject of an investigation by any licensing board or hospital as of the date of this application?

18. Attach a complete resume of all of your dental/dental hygiene activities, including your present position and specialty.

19. Attach documentation supporting mandatory continuing education credits.

20. Attach a copy of current CPR certification.

21. References: Listed below are four references whom I have supplied with the proper form that was included in my application packet.

**I understand that it is my responsibility to see that these forms are returned. I certify these references are not related to me, nor are they connected with any dental college I attended.**

Name \_\_\_\_\_ Name  
\_\_\_\_\_

Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

## 22. AFFIDAVIT OF APPLICATION

I acknowledge and state that I have read the Application Instructions that accompanied this application and I have answered all questions in compliance with these instructions. I acknowledge that it is my responsibility to read and become familiar with the Dental Practice Act and the Board Rules.

I further state that by submitting this application for a license to practice dentistry/dental hygiene in the State of Georgia, I hereby authorize and consent to have an investigation made as to the moral character, professional reputation and fitness for the practice of dentistry/ dental hygiene. I agree to give any further information in which may be required in reference to my past record. I understand that I will not receive a copy of the report or know its contents and I further understand that the contents of the investigative report will be privileged unless determined otherwise by the Board of Court Order.

I authorize and request every person, hospital, clinic, community, governmental agency (local, state, federal or foreign), court, association, institution, or other organization having control of any documents, records and other information pertaining to me, to furnish to the Georgia Board of Dentistry any information, including documents, records, regarding charges or complaints filed against me, formal or informal, pending or closed, or any other pertinent data and to permit the Georgia Board of Dentistry or any of its agents or representatives to inspect and make copies of such documents, records and other information, in connection with this application, subsequent licensure or practice thereunder.

I hereby release, discharge and exonerate the Georgia Board of Dentistry, it's agents or representatives, and any person so furnishing information, from any and all liability of every nature and kind arising out of the furnishing or inspection of such documents, records or other information or the investigation made by the Georgia Board of Dentistry. I authorize the Georgia Board of Dentistry to release information, material, documents, orders or the like relating to me or to this application to any other State or Territory of the United States or Province of Canada, a law enforcement agency, a hospital or other appropriate agencies as determined by the Board.

I, the undersigned, do hereby affirm under penalty of perjury that all statements made and information contained in this application are true and correct to the best of my knowledge and belief. Further, I consent to a thorough investigation of my employment record and other information that may be necessary to verify my qualifications to practice. I understand that any final disciplinary action that may ever be taken against my license, if it is granted, would be provided to a national disciplinary reporting system and that my Social Security number would be a part of that report.

By signing this application, electronically or otherwise, I hereby swear and affirm one of the following to be true and accurate pursuant to O.C.G.A. § 50-36-1:

1) \_\_\_\_\_ I am a United States citizen 18 years of age or older. **Please submit a copy of your current Secure and Verifiable Document(s) such as driver's license, passport, or other document as indicated on pages 16 & 17 of this application.**

Revised 11-8/2011

2) \_\_\_\_\_ I am not a United States citizen, but I am a legal permanent resident of the United States 18 years of age or older, or I am a qualified alien or non-immigrant under the Federal Immigration and Nationality Act 18 years of age or older with an alien number issued by the Department of Homeland Security or other federal immigration agency. **Please submit a copy of your current immigration document(s) which includes either your Alien number or your I-94 number and, if needed, SEVIS number.**

In making the above attestation, I understand that any failure to make full and accurate disclosures may result in disciplinary action by the Georgia Board of Dentistry and/or criminal prosecution.

This is to certify that the foregoing information is true and correct to the best of my knowledge.

\_\_\_\_\_  
Signature of Applicant

Date \_\_\_\_\_

(PHOTOGRAPH)  
Please attach recent photograph

\_\_\_\_\_  
(Print Name Above)

County \_\_\_\_\_ State \_\_\_\_\_

being duly sworn, says that he/she is the person who executed the above application for license to practice dentistry/dental hygiene in the State of Georgia; and that all the statements herein contained are true in every respect and that the attached photo is a true photo of the applicant.

\_\_\_\_\_ **Notary Public**

**Notary: Do not notarize this section unless photograph is attached.**

Sworn to and subscribed before me this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_.

(SEAL) My Commission Expires \_\_\_\_\_



## STATE LICENSURE CERTIFICATION

**TO THE APPLICANT:** *Please complete the top section of this form and mail to each state in which you are now or have been licensed to practice dentistry/dental hygiene. This form may be reproduced as necessary.*

**TO:** \_\_\_\_\_ **Board of Dentistry**

I am applying for reinstatement of my Georgia Dental/Dental Hygiene license and the Georgia Board requires that your Board complete this form in order that my application for reinstatement may be considered. By signing this form, I am giving my consent to the release of any information, favorable or otherwise, for its review in considering me for reinstatement.

My license Number \_\_\_\_\_ was issued by your Board on \_\_\_\_\_ on the basis of ( ) State Board Exam, ( ) Reciprocity/Endorsement, ( ) National Board, ( ) Credentials, ( ) other

\_\_\_\_\_  
Applicant's Full Name (print or type)

\_\_\_\_\_  
Address

\_\_\_\_\_  
City                  State                  ZIP

***This section to be completed by an official of the above referenced licensing board.***

\_\_\_\_\_  
Dental License Number \_\_\_\_\_ to practice dentistry/dental hygiene

in the State of \_\_\_\_\_ was issued on \_\_\_\_\_ to

\_\_\_\_\_  
Licensee

Is license current and in good standing? \_\_\_\_\_ Yes \_\_\_\_\_ No\*

Has any disciplinary action ever been taken against this license?

\_\_\_\_\_ Yes\* \_\_\_\_\_ No

\*Please provide complete details, including copies of any documents.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

(State Seal)



**OFFICE OF SECRETARY OF STATE  
PROFESSIONAL LICENSING BOARDS DIVISION  
237 Coliseum Drive  
Macon, Georgia 31217  
(478) 207-2440**

**CONSENT FORM**

I hereby authorize the Georgia Board of Dentistry ("Board") to receive any Georgia criminal history record information pertaining to me which may be in the files of any state or local criminal justice agency in Georgia.

\_\_\_\_\_  
Full Name (Print)

\_\_\_\_\_  
Physical Address (P.O. Boxes NOT Accepted)

\_\_\_\_\_  
City, State, Zip

\_\_\_\_\_  
Sex

\_\_\_\_\_  
Race

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Social Security Number

**One of the following must be checked:**

This authorization is valid for 90/180/\_\_\_ (circle one) days from date of signature.

I, \_\_\_\_\_ give consent to the Board to perform periodic criminal history background checks for the duration of my licensure with this state.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

Special licensure provisions (check if applicable):

\_\_\_ Working with mentally disabled

\_\_\_ Working with elder care

\_\_\_ Working with children

**GEORGIA BOARD OF DENTISTRY**  
**237 Coliseum Drive**  
**Macon, Georgia 31217**  
**(478) 207-1686**

REINSTATEMENT REFERENCE FORM

NAME OF APPLICANT \_\_\_\_\_

**TO REFERENCE SOURCE:** Please complete this form, sign it, and send it to the applicant in a **sealed envelope**. Your response is treated confidentially, pursuant to Georgia law. All applicants are required to sign a general release which is on file at the Board office. Please answer all questions.

FROM: \_\_\_\_\_  
Full Name Phone Number including Area Code

\_\_\_\_\_  
Address

\_\_\_\_\_  
City State Zip Code

1. How long have you known the applicant? \_\_\_\_\_ years
2. In what capacity have you know him/her? \_\_\_\_\_

- |                                                                                                                                                                                 |                          |                          |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|
| 3. Have you ever received reports of poor dental/dental hygiene practice by this dentist/dental hygienist <b>OR</b> have you discussed concerns you had about his/her practice? | YES                      | NO                       |
|                                                                                                                                                                                 | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Are you aware of any derogatory information about this person with respect to his/her ability to practice dentistry/dental hygiene?                                          | YES                      | NO                       |
|                                                                                                                                                                                 | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Does he/she enjoy professional respect among his/her colleagues and in the community where he/she practices?                                                                 | YES                      | NO                       |
|                                                                                                                                                                                 | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Are you aware of any lawsuits having to do with dental/dental hygiene practice that this dentist/dental hygienist has either lost or settled out of court?                   | YES                      | NO                       |
|                                                                                                                                                                                 | <input type="checkbox"/> | <input type="checkbox"/> |

COMMENTS

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature

Date

Title

**GEORGIA BOARD OF DENTISTRY**  
**237 Coliseum Drive**  
**Macon, Georgia 31217**  
**(478) 207-2440**

REINSTATEMENT REFERENCE FORM

NAME OF APPLICANT \_\_\_\_\_

**TO REFERENCE SOURCE:** Please complete this form, sign it, and **return to applicant in a sealed envelope.** Your response is treated confidentially, pursuant to Georgia law. All applicants are required to sign a general release which is on file at the Board office. Please answer all questions.

FROM: \_\_\_\_\_  
Full Name Phone Number including Area Code

\_\_\_\_\_  
Address

\_\_\_\_\_  
City State Zip Code

1. How long have you known the applicant? \_\_\_\_\_ years
2. In what capacity have you know him/her? \_\_\_\_\_

- |                                                                                                                                                                                 | YES                      | NO                       |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|
| 3. Have you ever received reports of poor dental/dental hygiene practice by this dentist/dental hygienist <b>OR</b> have you discussed concerns you had about his/her practice? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Are you aware of any derogatory information about this person with respect to his/her ability to practice dentistry/dental hygiene?                                          | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Does he/she enjoy professional respect among his/her colleagues and in the community where he/she practices?                                                                 | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Are you aware of any lawsuits having to do with dental/dental hygiene practice that this dentist/dental hygienist has either lost or settled out of court?                   | <input type="checkbox"/> | <input type="checkbox"/> |

COMMENTS

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Signature Date Title

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**Macon, Georgia 31217**  
**(478) 207-2440**

REINSTATEMENT REFERENCE FORM

NAME OF APPLICANT \_\_\_\_\_

**TO REFERENCE SOURCE:** Please complete this form, sign it, and **return to applicant in a sealed envelope**. Your response is treated confidentially, pursuant to Georgia law. All applicants are required to sign a general release which is on file at the Board office. Please answer all questions.

FROM: \_\_\_\_\_

Full Name \_\_\_\_\_ Phone Number including Area Code \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

1. How long have you known the applicant? \_\_\_\_\_ years
2. In what capacity have you know him/her? \_\_\_\_\_

- |                                                                                                                                                                                 |                          |                          |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|
| 3. Have you ever received reports of poor dental/dental hygiene practice by this dentist/dental hygienist <b>OR</b> have you discussed concerns you had about his/her practice? | <b>YES</b>               | <b>NO</b>                |
|                                                                                                                                                                                 | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Are you aware of any derogatory information about this person with respect to his/her ability to practice dentistry/dental hygiene?                                          | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Does he/she enjoy professional respect among his/her colleagues and in the community where he/she practices?                                                                 | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Are you aware of any lawsuits having to do with dental/dental hygiene practice that this dentist/dental hygienist has either lost or settled out of court?                   | <input type="checkbox"/> | <input type="checkbox"/> |

COMMENTS

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Title

**GEORGIA BOARD OF DENTISTRY**  
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**(478) 207-2440**  
REINSTATEMENT REFERENCE FORM

NAME OF APPLICANT \_\_\_\_\_

**TO REFERENCE SOURCE:** Please complete this form, sign it, and **return to applicant in a sealed envelope.** Your response is treated confidentially, pursuant to Georgia law. All applicants are required to sign a general release which is on file at the Board office. Please answer all questions.

FROM: \_\_\_\_\_  
Full Name Phone Number including Area Code

\_\_\_\_\_  
Address

\_\_\_\_\_  
City State Zip Code

1. How long have you known the applicant? \_\_\_\_\_ years

2. In what capacity have you know him/her? \_\_\_\_\_

- |                                                                                                                                                                                 |                          |                          |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|
| 3. Have you ever received reports of poor dental/dental hygiene practice by this dentist/dental hygienist <b>OR</b> have you discussed concerns you had about his/her practice? | <b>YES</b>               | <b>NO</b>                |
|                                                                                                                                                                                 | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Are you aware of any derogatory information about this person with respect to his/her ability to practice dentistry/dental hygiene?                                          | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Does he/she enjoy professional respect among his/her colleagues and in the community where he/she practices?                                                                 | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Are you aware of any lawsuits having to do with dental/dental hygiene practice that this dentist/dental hygienist has either lost or settled out of court?                   | <input type="checkbox"/> | <input type="checkbox"/> |

COMMENTS

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Signature Date Title

### MALPRACTICE QUESTIONNAIRE

\_\_\_\_\_  
Name of Dentist/Dental Hygienist Business Telephone

\_\_\_\_\_  
Address City, State, ZIP

**MALPRACTICE CHARGES/ALLEGATIONS:** Include name of patient, age, sex, date of occurrence and location (include address).

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List names of other dentist and/or physicians: \_\_\_\_\_

\_\_\_\_\_

DISPOSITION:  Pending  Settled If settled, provide the following information: Settlement Date\_\_\_\_\_ Total Settlement Amount\_\_\_\_\_ Amount Attributable to you: \_\_\_\_\_  In Court  Out of Court

The Board requires that you furnish documentation of the above information directly from the insurance company or attorney to the above address. Such documentation should include plaintiff's complaint, settlement agreement, and/or court order.

\_\_\_\_\_  
Signature Date

COMPLETE ONE QUESTIONNAIRE ON EACH MALPRACTICE SUIT  
YOU MAY DUPLICATE THIS FORM.

If not, applicable, please write (N/A), sign and return with completed application.

**APPLICANT: PLEASE CHECK THE FORM OF IDENTIFICATION BELOW THAT YOU POSSESS. RETURN THIS FORM ALONG WITH A COPY OF YOUR APPROPRIATE DOCUMENTATION.**

\_\_\_\_\_  
**Name**

Secure and Verifiable Documents Under O.C.G.A. § 50-36-2  
Issued August 1, 2011 by the Office of the Attorney General, Georgia

The Illegal Immigration Reform and Enforcement Act of 2011 (“IIREA”) provides that “[n]ot later than August 1, 2011, the Attorney General shall provide and make public on the Department of Law’s website a list of acceptable secure and verifiable documents. The list shall be reviewed and updated annually by the Attorney General.” O.C.G.A. § 50-36-2(f). The Attorney General may modify this list on a more frequent basis, if necessary.

The following list of secure and verifiable documents, published under the authority of O.C.G.A. § 50-36-2, contains documents that are verifiable for identification purposes, and documents on this list may not necessarily be indicative of residency or immigration status.

\_\_\_\_\_ A United States passport or passport card [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

\_\_\_\_\_ A United States military identification card [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

\_\_\_\_\_ A driver’s license issued by one of the United States, the District of Columbia, the Commonwealth of Puerto Rico, Guam, the Commonwealth of the Northern Marianas Islands, the United States Virgin Island, American Samoa, or the Swain Islands, provided that it contains a photograph of the bearer or lists sufficient identifying information regarding the bearer, such as name, date of birth, gender, height, eye color, and address to enable the identification of the bearer [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

\_\_\_\_\_ An identification card issued by one of the United States, the District of Columbia, the Commonwealth of Puerto Rico, Guam, the Commonwealth of the Northern Marianas Islands, the United States Virgin Island, American Samoa, or the Swain Islands, provided that it contains a photograph of the bearer or lists sufficient identifying information regarding the bearer, such as name, date of birth, gender, height, eye color, and address to enable the identification of the bearer [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

\_\_\_\_\_ A tribal identification card of a federally recognized Native American tribe, provided that it contains a photograph of the bearer or lists sufficient identifying information regarding the bearer, such as name, date of birth, gender, height, eye color, and address to enable the identification of the bearer. A listing of federally recognized Native American tribes may be found at:  
<http://www.bia.gov/WhoWeAre/BIA/OIS/TribalGovernmentServices/TribalDirectory/index.htm> [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

\_\_\_\_\_A United States Permanent Resident Card or Alien Registration Receipt Card [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

\_\_\_\_\_An Employment Authorization Document that contains a photograph of the bearer [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

\_\_\_\_\_A passport issued by a foreign government [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

\_\_\_\_\_A Merchant Mariner Document or Merchant Mariner Credential issued by the United States Coast Guard [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

\_\_\_\_\_A Free and Secure Trade (FAST) card [O.C.G.A. § 50-36-2(b)(3); 22 CFR § 41.2]

\_\_\_\_\_A NEXUS card [O.C.G.A. § 50-36-2(b)(3); 22 CFR § 41.2]

\_\_\_\_\_A Secure Electronic Network for Travelers Rapid Inspection (SENTRI) card [O.C.G.A. § 50-36-2(b)(3); 22 CFR § 41.2]

\_\_\_\_\_A driver's license issued by a Canadian government authority [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

\_\_\_\_\_A Certificate of Citizenship issued by the United States Department of Citizenship and Immigration Services (USCIS) (Form N-560 or Form N-561) [O.C.G.A. § 50-36-2(b)(3); 6 CFR § 37.11]

\_\_\_\_\_A Certificate of Naturalization issued by the United States Department of Citizenship and Immigration Services (USCIS) (Form N-550 or Form N-570) [O.C.G.A. § 50-36-2(b)(3); 6 CFR § 37.11]

\_\_\_\_\_In addition to the documents listed herein, if, in administering a public benefit or program, an agency is required by federal law to accept a document or other form of identification for proof of or documentation of identity, that document or other form of identification will be deemed a secure and verifiable document solely for that particular program or administration of that particular public benefit. [O.C.G.A. § 50-36-2(c)]