STATE OF IOWA
IOWA DENTAL BOARD

TERRY E. BRANSTAD, GOVERNOR
KIM REYNOLDS, LT. GOVERNOR

JILL STUECKER
EXECUTIVE DIRECTOR

Iowa Temporary Permit Application
~Volunteer Services~

Application Form

Please find enclosed the application for a temporary permit for the practice of dentistry or dental hygiene in Iowa.

Please note: *Temporary permits are not meant as a way to practice before a permanent license is issued.*

When completing this application, please be advised of the following:

- Temporary permits are valid at specific location(s) for a period of up to three months.
- For specific permit requirements, please refer to the Board's rules at Iowa Administrative Code 650—Chapter 13.
- Type or legibly print all information requested in the application. Complete all questions. If not applicable, please mark sections 'N/A'.
- Permits are issued administratively following review of a completed application and all required documentation, unless the application warrants referral to the Licensure/Registration Committee, the full Board, or unless a personal appearance is required.
- Applications are valid for only 180 days from the date of receipt. If the application has not been completed within 180 days, a new application and fee will have to be submitted if you wish to obtain an Iowa temporary permit.
- **Failure to answer all questions completely or accurately, and/or omission or falsification of material facts may be cause for denial of your application, or disciplinary action if you are subsequently issued a temporary permit by the Board.**
- In the state of Iowa, dentists cannot administer deep sedation/general anesthesia or moderate sedation in the practice of dentistry unless a separate permit has been obtained from the Iowa Dental Board. Likewise, dental hygienists cannot administer local anesthesia without a separate permit obtained from the Iowa Dental Board. You may download the applications for sedation or local anesthesia permit at http://www.dentalboard.iowa.gov/forms/index.html, or you may contact the Board office.

Volunteer Services: To qualify for a temporary permit for volunteer services, you must have graduated from an ADA-accredited dental or dental hygiene program, have been licensed and practicing for no less than three years in another state, and at least one license must have been issued on the basis of clinical examination. Also, you must provide your services at a free or nonprofit dental clinic, and you may not be compensated for the services provided, either directly or indirectly.

Public Information
All or part of the information provided on the application form may be considered a public record under Iowa Code Chapter 22 and Iowa Administrative Code 650—Chapter 6. Information about misconduct and examination results may not be subject to disclosure.

Disclosure of Medical Conditions, Criminal History, Disciplinary Actions and Malpractice Claims
Be advised that the application for temporary permit asks about any medical conditions you have that might impair your ability to practice the profession. The Board also considers any prior criminal history, disciplinary actions and malpractice claims when issuing temporary permits. As part of the application process you will be asked questions about prior criminal history, disciplinary action, and malpractice claims.

If you have any questions concerning these requirements, please notify the Board office. If any of these situations pertain to you, there may be delays at the time of issuance. We suggest you contact the Board office for information as to what documentation may be necessary. Contacting the Board office about any of these situations may avoid unnecessary delays at the time of issuance.

Application Checklist

☐	Application completely filled out; all questions answered.
☐	Notarized copy of marriage certificate or divorce decree (if applicant's name is different on documentation)
☐	Affidavit of Applicant
☐	For each "Yes" answer to questions 1 through 22, you must provide a separate, signed statement giving full details, including date(s), location(s), action(s), organization(s) or parties involved, and specific reason(s).
☐	Authorization to Release Information (signed and dated)
☐	Copy of current CPR card (Online certification in CPR is not accepted.)
☐	License certification from the state, "home jurisdiction", where applicant is currently licensed.
☐	A request for the temporary permit from the individual(s) or organization(s) seeking the applicant's services that establishes the justification for the temporary permit, the dates of service requested, and the location(s) where the services will be provided.

Contact Us
If you have any questions, or need further assistance, please feel free to contact the Iowa Dental Board at (515) 281-5157 or IDB@iowa.gov.

Board website: www.dentalboard.iowa.gov.
Board rules and Iowa Code chapters: http://www.dentalboard.iowa.gov/board/rules-policy/index.html.

APPLICATION FOR IOWA TEMPORARY PERMIT – VOLUNTEER SERVICES

IOWA DENTAL BOARD
400 S.W. 8th Street, Suite D, Des Moines, Iowa 50309-4687
Ph. (515) 281-5157 http://www.dentalboard.iowa.gov

☐ **Dental Temporary Permit** ☐ **Dental Hygiene Temporary Permit**

This form must be completed and returned to the Iowa Dental Board. Complete each question on the application. If not applicable, mark "N/A."

Full Legal Name: (Last, First, Middle)			
Other Names Used: (e.g. Maiden Name)			
Home Address:			
City:	**County:**	**State:**	**Zip:**
Home Phone:		**Home E-mail:**	
Temporary Work Address:			
Temporary City:	**Temporary County:**	**Temporary State:**	**Temporary Zip:**
Temporary Work Phone:	**Temporary Work Fax:**	**Temporary Work E-mail:**	

DENTAL/DENTAL HYGIENE EDUCATION

Degree Received:	**Date of Degree:**

LICENSE INFORMATION

List all state/countries in which you are or have ever been licensed. All licenses must be verified. Contact the Board with any questions.

State/Country	License No.	Date Issued	License Type (e.g. Resident, Faculty, Permanent)	How Obtained (e.g. Credentials, Exam)

For office use only:	**License #:**	**Date Issued:**	**Fee:**

Name of Applicant: _____

PERSONAL & CONFIDENTIAL DATA

Privacy Act Notice: Disclosure of your Social Security Number on this license application is required by 42 U.S.C. § 666(a)(13), Iowa Code §§ 272J.8(1) and 261.126(1), and Iowa Code § 272D.8(1). The number will be used in connection with the collection of child support obligations, college student loan obligations, and debts owed to the state of Iowa, and as an internal means to accurately identify licensees, and may also be shared with taxing authorities as allowed by law including Iowa Code § 421.18.			
Social Security Number:		**Gender:** ☐ Male ☐ Female	**U.S. citizen:** ☐ Yes ☐ No
If no, visa type or alien registration number: ☐ Student Visa ☐ Work Visa ☐ Alien Registration **Provide visa/alien registration number:** **If visa, provide expiration date of current visa:**			
Date of birth:	**City of Birth:**	**State of birth:**	**Country of birth:**

DEFINITIONS

Important! Read these definitions before completing the following questions.

"Ability to practice with reasonable skill and safety" means ALL of the following:

1. The cognitive capacity to make appropriate clinical diagnosis, exercise reasoned clinical judgments, and to learn and keep abreast of clinical developments;
2. The ability to communicate clinical judgments and information to patients and other health care providers; and
3. The capability to perform clinical tasks such as dental examinations and dental surgical procedures.

"Medical condition" means any physiological, mental, or psychological condition, impairment, or disorder, including drug addiction and alcoholism.

"Chemical substances" means alcohol, legal and illegal drugs, or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

"Currently" does not mean on the day of, or even in weeks or months preceding the completion of this application. Rather, it means recently enough so that the use of chemical substances or medical conditions may have an ongoing impact on the ability to function and practice, or has adversely affected the ability to function and practice within the past two (2) years.

"Improper use of drugs or other chemical substances" means ANY of the following:

1. The use of any controlled drug, legend drug, or other chemical substance for any purpose other than as directed by a licensed health care practitioner; and
2. The use of any substance, including but not limited to, petroleum products, adhesive products, nitrous oxide, and other chemical substances for mood enhancement.

"Illegal use of drugs or other chemical substances" means the manufacture, possession, distribution, or use of any drug or chemical substance prohibited by law.

Name of Applicant: _____

PERSONAL & CONFIDENTIAL DATA

In answering each of the following questions, please check the appropriate box next to each question. **FOR EACH "YES" ANSWER TO QUESTIONS 1 THROUGH 22, YOU MUST PROVIDE A SIGNED STATEMENT GIVING FULL DETAILS, INCLUDING DATE(S), LOCATION(S), ACTION(S), ORGANIZATION(S) OR PARTIES INVOLVED, AND SPECIFIC REASON(S).**

Yes ☐	**No** ☐	1. Do you currently have a medical condition that in any way impairs or limits your ability to practice with reasonable skill and safety?
Yes ☐	**No** ☐	2. Are you currently engaged in the illegal or improper use of drugs or other chemical substances?
Yes ☐	**No** ☐	3. Do you currently use alcohol, drugs, or other chemical substances that would in any way impair or limit your ability to practice with reasonable skill and safety?
Yes ☐	**No** ☐	4. If YES to any of the above, are you receiving ongoing treatment or participating in a monitoring program that reduces or eliminates the limitations or impairments caused by either your medical condition or use of alcohol, drugs, or other chemical substances?
Yes ☐	**No** ☐	5. If YES to any of the above, does your field of practice, the setting, or the manner in which you have chosen to practice, reduce or eliminate the limitations or impairments caused by either your medical condition or use of alcohol, drugs, or other chemical substances?

If you answered yes to any of the questions above, please provide a statement below providing the details as requested in the instructions above. Please add a separate sheet of paper if necessary.

_____

_____

_____

_____

_____

_____

_____

_____

_____

Signature **Date**

Name of Applicant: _____

In answering each of the following questions, please check the appropriate box next to each question. **FOR EACH "YES" ANSWER TO QUESTIONS 1 THROUGH 22, YOU MUST PROVIDE A SIGNED STATEMENT GIVING FULL DETAILS, INCLUDING DATE(S), LOCATION(S), ACTION(S), ORGANIZATION(S) OR PARTIES INVOLVED, AND SPECIFIC REASON(S).**		
Yes ☐	**No** ☐	6. Except for minor speeding or parking offenses, have you ever been arrested, charged, convicted, found guilty of, or entered a plea of guilty or no contest to a felony or misdemeanor crime or offense, including actions that resulted in a deferred or expunged judgment?
Yes ☐	**No** ☐	7. Have you ever been terminated or requested to withdraw from any dental school or training program?
Yes ☐	**No** ☐	8. Have you ever been requested to repeat a portion of any professional training program/school?
Yes ☐	**No** ☐	9. Have you ever received a warning, reprimand, or been placed on probation during a professional training program/school?
Yes ☐	**No** ☐	10. Have you ever been denied a license to practice?
Yes ☐	**No** ☐	11. Have you ever voluntarily surrendered a license issued to you by any professional licensing agency?
Yes ☐	**No** ☐	11a. If yes, was a license disciplinary action pending against you, or were you under investigation by a licensing agency at that time the voluntary surrender of license was tendered?
Yes ☐	**No** ☐	12. Have you ever been denied a Drug Enforcement Administration (DEA) or state controlled substance registration certificate?
Yes ☐	**No** ☐	13. Have you ever surrendered your state or federal controlled substance registration or had it restricted in any way?
Yes ☐	**No** ☐	14. Aside from ordinary initial requirements of proctorship, have your clinical activities ever been limited, suspended, revoked, not renewed, voluntarily relinquished, or subject to other disciplinary or probationary conditions?
Yes ☐	**No** ☐	15. Have you ever been terminated, sanctioned, penalized, had to repay monies to, or been denied provider participation in any state Medicaid, federal Medicare, or other publicly funded health care program?
Yes ☐	**No** ☐	16. Are any malpractice claims or complaints in process/pending against you?
Yes ☐	**No** ☐	17. Have any settlement agreements been rendered or any judgments entered against you resulting from your practice?
Yes ☐	**No** ☐	18. Are charges or an investigation currently pending relative to your dental license in any other state?
Yes ☐	**No** ☐	19. Has any jurisdiction of the United States or other nation ever limited, restricted, warned, censured, placed on probation, suspended, or revoked a license you held?
Yes ☐	**No** ☐	20. Have you ever been notified of any charges filed against you by a licensing or disciplinary agency of any jurisdiction of the U.S. or other nation?

Name of Applicant: _____

In answering each of the following questions, please check the appropriate box next to each question. **FOR EACH "YES" ANSWER TO QUESTIONS 1 THROUGH 22, YOU MUST PROVIDE A SIGNED STATEMENT GIVING FULL DETAILS, INCLUDING DATE(S), LOCATION(S), ACTION(S), ORGANIZATION(S) OR PARTIES INVOLVED, AND SPECIFIC REASON(S).**		
Yes ☐	**No** ☐	21. Do you have professional liability suits in process or pending?
Yes ☐	**No** ☐	22. Have any judgments or settlements been paid on your behalf as a result of a professional liability case(s)?
Yes ☐	**No** ☐	**23. Do you understand that if a license is granted by this board, it will be based in part on the truth of the statements contained herein, which, if false, may subject you to criminal prosecution and revocation of the license?**
Yes ☐	**No** ☐	**Pursuant to IAC 650—13.3(3)b(8), I hereby certify that I shall only practice in a free dental clinic or a dental clinic for a nonprofit organization and I shall not receive compensation, either directly or indirectly, for providing dental services while I hold a temporary permit in Iowa.**

AFFIDAVIT OF APPLICANT

I declare, under penalty of perjury, that my answers and all statements made by me on this application and accompanying attachments are true and correct. Should I furnish any false information, or have substantial omission, I hereby agree that such act shall constitute cause for denial, suspension, or revocation of my temporary permit. I also declare under penalty of perjury that if I did not personally complete the foregoing application that I have fully read and confirmed each question and accompanying answer, and take full responsibility for all answers contained in this application.

I hereby agree to abide by the laws and rules pertaining to the practice of dentistry/dental hygiene in the state of Iowa.

Signature of Applicant _____ Date _____

AUTHORIZATION TO RELEASE INFORMATION

I, _____, do hereby authorize a disclosure of records concerning myself to the Iowa Dental Board (IDB). This release includes records of a public, private or confidential nature.

I acknowledge that the information released to the IDB may include material that is protected by federal and/or state laws applicable to substance abuse and mental health information. If applicable, I specifically authorize the release of confidential information to and from the IDB relating to substance abuse or dependence and/or mental health.

I further agree that the IDB may receive confidential information and records, including but not limited to the following records:

- Medical records
- Education records
- Personnel or employment records, including records of any remedial, probationary, disciplinary, or any other adverse information contained in those records.
- Residency or fellowship training records, including records of any remedial, probationary, disciplinary, or any other adverse information contained in those records.
- Any information the IDB deems reasonably necessary for the purposes set forth in this release.

Release of Liability. I do hereby irrevocably and unconditionally release, covenant not to sue, and forever discharge any person or entity, including but not limited to any dental school, residency or fellowship training program, hospital, health care provider, health care facility, licensing board, impaired practitioner program, agency, or organization, which releases information to the IDB pursuant to this release from any liability, claim, or cause of action arising out of the release of such information. I further irrevocably and unconditionally release, covenant not to sue, and forever discharge the IDB, the State of Iowa, and its employees and agents from any liability, claim, or cause of action arising out of the collection or release of information pursuant to this release.

A photocopy of this release form will be valid as an original thereof, even though the photocopy does not contain an original writing of my signature.

This authorization is effective through the completion of the licensure process. I understand I have the right to revoke this authorization in writing, except to the extent that the IDB has already taken action in reliance upon this consent.

I have read and fully understand the contents of this "Authorization to Release Information."

_____ _____

Signature of Applicant **Date**

PROHIBITION ON REDISCLOSURE

This form does not authorize redisclosure of medical information beyond the limits of this consent. Where information has been disclosed from records protected by federal law for alcohol/drug abuse records or by state law for mental health records, federal requirements (42 C.F.R. Part 2) and state requirements (Iowa Code Ch. 228) prohibit further disclosure without the specific written consent of the patient except as provided in IAC 12.16(6)"b"2, or as otherwise permitted by such law and/or regulations. A general authorization for the release of medical or other information is not sufficient for these purposes. Civil and/or criminal penalties may attach for unauthorized disclosure of alcohol/drug abuse or mental health information.

CERTIFICATION OF EDUCATION

As part of the license application process, the Iowa Dental Board requires that the school at which the applicant received her/his dental or dental hygiene education complete this form. The completed form must be mailed directly from the school to the **IOWA DENTAL BOARD.** Any processing fees are the applicant's responsibility. The applicant's signature authorizes release of information, favorable or otherwise, directly to the board.

Print Name: _____ **Date of Birth or Last 4 of SSN: _____**

Signature: _____ **Date: _____**

****

This portion of the form should be completed by the school.

IT IS HEREBY CERTIFIED THAT _____
(Name of Applicant)

RECEIVED DENTAL EDUCATION AT_____
(Name of School)

LOCATED AT_____
(Full Address of School)

FROM _____ TO _____
(Month/Year) (Month/Year)

GRANTED A DIPLOMA WITH THE DEGREE OF_____

DATE DIPLOMA RECEIVED _____
(Month/Year)

Was the school accredited by the Commission on Dental Accreditation of the American Dental Association at the time the applicant graduated? **Yes** _____ **No** _____

Did the student ever receive a warning, reprimand? **Yes** _____ **No** _____

Was the student placed on probation or disciplined? **Yes** _____ **No** _____

If yes, please provide details concerning the action taken.

President, Dean, Secretary, or Registrar:

Print Name_____ **Title_____**

Signature_____ **Date_____**

Phone #_____ **Fax #_____**

SCHOOL SEAL

Return Completed Form to:
IOWA DENTAL BOARD
400 S.W. 8th St, Suite D
Des Moines, IA 50309-4687
Phone (515) 281-5157

CERTIFICATION OF LICENSURE

As part of the license application process, the Iowa Dental Board requires that this form be completed by every board that has ever issued any license to the applicant, even if the license is not current. The completed form must be mailed directly from the state licensing board to the **IOWA DENTAL BOARD.** Any processing fees are the applicant's responsibility. The applicant's signature authorizes release of information, favorable or otherwise, directly to the board.

Print Name: _____ **License #: _____**

Signature: _____ **Date: _____**

****

This portion of the form should be completed by the state licensing board.

IT IS HEREBY CERTIFIED THAT _____
(Name of Applicant)

WAS GRANTED LICENSE NUMBER _____ DATE ISSUED _____

TO PRACTICE _____ IN THE STATE OF _____

DATE OF EXPIRATION _____ LICENSE STATUS _____

BASIS FOR LICENSURE:

☐ **NATIONAL BOARD EXAM**
☐ **LICENSURE BY CREDENTIALS**
☐ **STATE BOARD PREPARED WRITTEN AND/OR PRACTICAL EXAM**
☐ **REGIONAL CLINICAL EXAM, NAME OF TESTING AGENCY_____**

☐ **SCORES ARE RECORDED AS FOLLOWS:**

SUBJECT	PERCENT	SUBJECT	PERCENT
_____		_____	
_____		_____	
_____		_____	

☐ Scores are no longer available, however, I certify that it is apparent the applicant received a score sufficient to meet the licensure requirements of this state at that time; and these requirements were substantially equivalent to the requirements for licensure in Iowa.

☐ **YES** ☐ **NO** **Disciplinary action ever been initiated, pending, or taken?**

Print Name _____ **Title_____**

Signature _____ **Date_____**

Phone # _____ **Fax #_____**

STATE OR BOARD SEAL

Return Completed Form to:
IOWA DENTAL BOARD
400 S.W. 8th St, Suite D
Des Moines, IA 50309-4687
Phone (515) 281-5157