Dentist Check List:

Initial

____Application

____Nonrefundable application fee of $100 (made payable to **"CNMI TREASURER"**)

____2x2 photo

____Applicant is a graduate of a dental school accredited by the Commission on Dental Accreditation (CODA) of the American Dental Association (ADA) or the Commission on Dental Accreditation of Canada; and

____Applicant has taken and passed the examination administered by the Joint Commission on National Dental Examinations or the written examination and the Objective Structured Clinical Examination (OSCE) administered by the National Dental Examiner Board of Canada; or

____Copy of current and valid license from another jurisdiction;

____A curriculum vitae including a detailed education and experience history which shall include dates, places, institutions, educational programs, and description of all prior education and work experience; and

____A list of all sanctions, judgments, awards, settlements, or convictions against the applicant in any jurisdiction, U.S. or foreign, that may constitute grounds for disciplinary action in that jurisdiction or be of concern to the Board; and

____A current report from the National Practitioner Data Bank (NPDB), the American Association of Dental Examiners Clearinghouse for Board Actions, or any other entity having information pertinent to the applicant's performance; and

Copies acceptable to the Board of the following:

____Diploma showing a degree of Doctor of Dental Surgery or Doctor of Dental Medicine; and

____Current and active license to practice as a dentist in any U.S. state or Canada; and

____Current DEA registration certificate, if held by the applicant.

Renewal

____Renewal application
____2x2 photo
____Nonrefundable fee of $100 payable to **"CNMI TREASURER"**
____Submit proof of forty (40) CDE hours (20 hours per year)

-Schedule of Fees

Application fee	$100
Initial license fee for Dental Hygiene and Dental Therapist	$100
Initial license fee for Dentist	$200
Renewal fee for Dental Hygiene and Dental Therapist	$100
Renewal fee for Dentist	$200
Temporary license fee	$100
Delinquent fee (charged every 1st of the month after expiration date)	$25
Replacement/Duplication of license	$75
Replacement/Duplication of wallet size card	$25
Letter of Good Standing/Verification fee	$25

Dental Hygiene Check List:

Initial license

____Application

____Nonrefundable fee of $100 payable to **"CNMI TRESURER"**

____ Completed application with information that includes the applicant's full name and all aliases or other names ever used, current address, date and place of birth, and social security number; and

____Current 2x2 photograph of the applicant taken within six months from date of application; and

____A list of all jurisdictions, U.S. or foreign, in which the applicant has ever been licensed, has applied for a license to practice dental hygiene, has been denied licensure, or voluntarily surrendered a license to practice dental hygiene; and

____A curriculum vitae including a detailed education and experience history which shall include dates, places, institutions, educational programs, and description of all prioreducation and work experience; and

____A list of all of all sanctions, judgments, awards, settlements, or convictions against the applicant in any jurisdiction, U.S. or foreign, that may constitute grounds for disciplinary action in that jurisdiction or be of concern to the Board; and

____Notarized or certified copies acceptable to the Board of the following: A diploma showing a degree of Dental Hygiene; and

____Document showing proof that applicant has taken and passed the National Board Dental Hygiene examination administered by the Joint Commission on National Dental Examinations or the Canadian National Board Dental Hygiene Examination; or

____Current and active license to practice as a dental hygienist in any U.S. state or Canada.

Renewal

____Renewal application

____2x2 photo

____Submit proof of twenty-four (24) CDE hours (12 hours per year)

____Nonrefundable renewal fee of $100 payable to **"CNMI TREASURER"**

Dental Therapy Check List:

Initial

____Application

____Nonrefundable application fee of $100 (made payable to **"CNMI TREASURER"**)

____Completed application with information that includes the applicant's full name and all aliases or other names ever used, current address, date and place of birth, and social security number; and

____Current 2x2 photograph of the applicant taken within six months from date of application; and

____A list of all jurisdictions, U.S. or foreign, in which the applicant has ever been licensed or has applied for a license to practice as a dental therapist or a dentist; has been denied licensure; or voluntarily surrendered a license to practice as a dental therapist or dentist; and

____A curriculum vitae including a detailed education and experience history which shall include dates, places, institutions, educational programs, and description of all prior education and work experience; and

____A list of all sanctions, judgments, awards, settlements, or convictions against the applicant in any jurisdiction, U.S. or foreign, that may constitute grounds for disciplinary action in that jurisdiction or be of concern to the Board; and

____Notarized or certified copies acceptable to the Board of the following:

- ____Diploma showing a degree of Dental Therapy or a degree of Doctor of Dental Surgery from a school of dentistry recognized by the department of health in that respective country; and

- ____Documents showing proof that applicant is licensed to practice as a dental therapist in any U.S. state or Canada, or a foreign trained dentist graduated from a school of dentistry recognized by the department of health in that respective country;

Renewal

____Renewal application

____2x2 photo

____Nonrefundable fee of $100 payable to "CNMI TREASURER"

____Submit proof of twenty-four (24) CDE hours (12 hours per year)

Commonwealth of the Northern Mariana Islands
HEALTH CARE PROFESSIONS LICENSING BOARD
P.O. Box 502078, Bldg., 11925 Pohnpei Court
Capitol Hill, Saipan, MP 96950
Tel No: (670) 664-4809 Fax: (670) 664-4814
Email: info@cnmilicensing.gov.mp
Website: www.cnmilicensing.gov.mp

Attach a recent 2x2 ID photo here taken within 6 months of the application.

APPLICATION FOR DENTISTS, DENTAL HYGIENISTS & DENTAL THERAPISTS

Type of License Applying for:

☐ Initial	☐ Endorsement	☐ Temporary
☐ Dentist	☐ Dental Hygienist	☐ Dental Therapist

HCPLB STAFF USE ONLY
Date Received:

APPLICATION INFORMATION – Please Type or Print

1. Last:	First:	Middle:	**2.** Social Security No:
3. Birthdate: (Mo/Day/Yr.)	**4.** Color of Eyes: Color of Hair:	**5.** Height: Weight:	**6.** Sex:
7. Mailing Address:		**8.** Email Address:	
9. Residence Address:		**10.** Phone No: (W): (H):	
11. NPI # (if available):		**12.** Citizenship: ____U.S. ____Other Specify:	

13. EDUCATION – (*Provide an original, notarized, or certified copy of your degree*)

Name of Schools	Location (City/State or Country)	Degree Earned	Dates (Mo/Yr.) From	To

14. EXAMINATION – (*List examination(s) you have taken and passed*)

Examination	Date	Result (Pass/Fail)

15. LICENSES – (*List of all jurisdictions where you are licensed or applied for a license.*)

Name of Jurisdiction	Date Issued	Expiration Date	License Number	Current Status

16. DENTAL AFFILIATIONS (if none state "None")

Name of Clinic	Location (City/State or Country)	Dates (Mo/Yr.) From	To

17. Name/Address of Intended Employment within the CNMI:

If you answer "yes" for any of items 18-35 you must attach a detailed explanation on a separate sheet, which includes state or country where action is pending or took place, relevant dates, action taken and reasons for such action. (Include Findings of Fact, Conclusion of Law, Final Order and whether you have been reinstated. If reinstated, date and conditions of license.)

Question	Yes	No
18. Have you ever been charged with, or been found to have committed dishonorable, unprofessional conduct, negligence, incompetence, misconduct, or repeated negligent acts by any licensing board, other agency, or clinic?	☐	☐
19. Has a claim or an action ever been filed against you for the practice of dentistry which resulted in a settlement, judgment, or arbitration award of $25.000 or more?	☐	☐
20. Has any licensing board, other agency, or disciplinary authority refused to issue you a license, renew your license, suspended, revoked, accepted surrender of your license, placed on probation or conditioned your license, held by you now or previously, or ever fined or otherwise disciplined you?	☐	☐
21. Is there any ongoing or pending investigation against you?	☐	☐
22. Is there any disciplinary action pending against you?	☐	☐
23. Has any clinic or licensed facility restricted or terminated your professional training, employment, or have you ever voluntarily or involuntarily resigned or withdrawn from such association to avoid imposition of such measures?	☐	☐
24. Have your DEA or state-controlled substance registration ever been denied, suspended, restricted, or terminated?	☐	☐
25. Have you ever entered into any arrangement or plea or agreement in lieu of a federal prosecution for a drug violation regulated by the DEA?	☐	☐
26. Have you ever been terminated, sanctioned, and penalized, had to repay monies to or been denied provider participation in any Medicaid, Medicare, or other publicly funded healthcare program?	☐	☐
27. Has your ability to practice dentistry in a competent and safe manner ever been impaired or limited by any condition, behavior, impairment, or limitation of a physical, mental, or emotional nature?	☐	☐
28. Have you used or are you currently using any chemical substance(s), legal or illegal, that in any way impaired or limited, or is currently impairing or limiting, your ability to practice dentistry in a safe and competent manner?	☐	☐
29. Have you been enrolled in, required to enter, or participated in any drug or alcohol recovery program or impaired practitioner program?	☐	☐
30. Have you been treated for or had a recurrence or a diagnosed addictive disorder?	☐	☐
31. Have you ever been diagnosed with a neurological or other physical condition that would impair your ability to practice dentistry safely?	☐	☐
32. Do you have any other condition in which in any way impairs or limits your ability to practice dentistry safely?	☐	☐
33. Have you ever been found guilty, pleaded guilty, no contest, or nolo contendere to a crime involving moral turpitude or crime related to the dental profession, or felony in any court?	☐	☐

	Yes	No
34. Is criminal action pending against you in any court?	☐	☐
35. Are you required to register as a Sex Offender?	☐	☐

36. **DECLARATION:**
I hereby certify that I am the person herein named subscribing to this application. I have read the complete application, and I know the full content hereof. I declare that all of the information contained herein, and evidence or other credentials submitted herewith are true and correct. I understand that any falsification or misrepresentation of any item or response in this application, or any attachment hereto or falsification on misrepresentation of credentials to support this application, is sufficient grounds for denying, revoking, or otherwise disciplining a license to practice medicine in the Commonwealth of the Northern Mariana Islands. I further certify that I have read and will abide by P.L. 15-105 and the Regulations for Dentists, Specialists, Dental Hygienists, Dental Therapists, and Dental Assistants.

________________________________ ________________
Signature of Applicant Date

*Please complete the application form and attach all original, certified, or notarized documents and a non-refundable application fee of $100.00 (money order or cashier's check make payable to "**CNMI Treasurer**"). Do not send cash.*

2022

AUTHORIZATION FOR RELEASE OF INFORMATION

I, ___________________________ (print name), do hereby authorize a disclosure of records concerning myself to the Health Care Professions Licensing Board (HCPLB). This release includes records of a public, private or confidential nature.

I acknowledge that the information released to the HCPLB 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 HCPLB relating to substance abuse or dependence and/or mental health.

I further agree that the HCPLB 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.
- Post-graduate training (internship, residency, and fellowship) records, including records or any remedial, probationary, disciplinary, or any other adverse information contained in those records.
- Any information the HCPLB 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 medical 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 HCPLB 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 HCPLB, the Commonwealth of the Northern Mariana Islands, 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.

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

___________________________ _____________
Signature of Applicant Date