



**Texas State Board of Dental Examiners**

333 Guadalupe, Tower 3, Suite 800  
 Austin, Texas 78701-3942  
 (512) 463-6400 / Fax: (512) 463-7452

**2x2 Passport Photo  
 Required**

**PLACE HERE**

**Dentist Faculty Member Application**

**Instructions: Print legibly or type all information. All fields are required. Submitting an incomplete application will delay your application process. All supporting documentation should be submitted with this application. Fees are Non-Refundable. Make your check or money order payable to TSBDE and mail to the Texas State Board of Dental Examiners at 333 Guadalupe St, Ste 3-800 Austin, TX 78701. A 2x2 passport photo is required.**

**Faculty License: \$194**

**Military Active Duty, Veteran, & Spouse: NO FEE:**

**Active Duty\*\***       **Veteran\*\***       **Active Duty Spouse\*\***

**\*\* Please include a copy of one of the following: Copy of Military Orders, I.D. Card or proof of Honorable or General Discharge**

Social Security #*:				Date of Birth: MM / DD / YYYY
Last Name:			First Name	Middle
Current Address:			City:	State:      Zip
Permanent Address:			City:	State:      Zip:
Business Address:			City:	State:      Zip:
Preferred mailing address: (preferred address will be made available to the public)				
<input type="checkbox"/> Current <input type="checkbox"/> Permanent <input type="checkbox"/> Business				
Daytime Phone #:			Email Address:	
Employing School:				
City:			Assigned Department:	

\* Pursuant to Sec. 59.001 of the Dental Practice Act, the social security number of an applicant for or holder of a license, certificate of registration, or other legal authorization issued by a licensing agency to practice in a specific occupation or profession that is provided to the licensing agency is confidential and not subject to disclosure under Chapter 552, Government Code.

**Dental Education:**

Name of School:	Degree Earned:	Graduation Date:
Name of School:	Degree Earned::	Graduation Date
Jurisprudence Completion Date:		

<b>Applicant Name:</b>	<b>Date:</b>
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**Health Insurance**

Are you a Texas Medicaid Provider? \_\_\_\_ Yes \_\_\_\_ No

Are you a participating provider in the Texas Children's Health Insurance Program (CHIP)? \_\_\_\_ Yes \_\_\_\_ No

**TO BE COMPLETED BY DEAN, DEPARTMENT CHAIR, OR PROGRAM DIRECTOR**

I, \_\_\_\_\_, verify that the above-named applicant holds a :  
 Part Time                       Full Time

Salaried position with the following teaching institution: \_\_\_\_\_ and is a fit and proper issued faculty license to provide direct patient care with this institution or its adjunct facilities.

Signature of Dean, Department Chair, or Program Director:	Date:
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**IN ADDITION TO THE FOREGOING:**

- A. I hereby give my permission for the Texas State Board Dental Examiners (TSBDE) to secure additional information or documentation concerning me or any of the statements in this application from any person or source the TSBDE may desire.
- B. I further agree to submit to questioning concerning my qualifications as an applicant by the TSBDE, staff, any member or agent thereof, and to substantiate my statements if desired by the TSBDE. I also agree to present all other credentials required or requested by the TSBDE.
- C. I, the applicant herein, state that all facts, statements, and answers contained in this application are true and correct. I am not omitting any information, which might be of value to the Board in determining my qualifications whether it is called for or not. I agree that any falsification, omission, or withholding pertinent information or facts concerning my qualifications as an applicant shall be sufficient to bar me from licensure by the TSBDE and such falsification, omission or withholding shall serve as sufficient grounds for the revocation, cancellation, or suspension of my Texas license if not discovered until after issuance.

Signature of Applicant:	Date:
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**STATE OF \_\_\_\_\_ COUNTY OF \_\_\_\_\_**

Before me, the undersigned authority, on this day personally appeared the applicant whose signature appears above and who being by me sworn upon oath says that all the facts, statements and answers contained in this application are true and correct.

Sworn and subscribed to before me, the said \_\_\_\_\_ appeared on this the \_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_\_, to certify which witness my hand and seal of office.

\_\_\_\_\_  
Notary Signature

(Seal)

## Faculty Dentist License Application Requirements Checklist

- Submit a fully completed application. Submitting an incomplete application will delay your application process.
- A 2x2 passport photo.
- Copy of driver's license, naturalization papers, or passport.
- Copy of current Basic Life Support CPR certification.
- Copy of a diploma from a dental school
- Endorsement from the Dean, Department Chair or Program Director of the employer-school verifying full-time or part-time salaried faculty position at a CODA-accredited dental school.
- Proof of completion of the Jurisprudence taken within one year immediately prior to application.
- National Practitioner Data Bank (NPDB) self-query report. Report results must remain in the original sealed envelope. NPDB reports are valid for 60 days. Contact NPDB at (800) 767-6732, or at <http://www.npdb.hrsa.gov/pract/howToGetStarted.jsp>.
- American Association of Dental Boards (AADB) self-query report results must remain in the original sealed envelope. Contact AADB at (312) 440-7464 or at <http://www.dentalboards.org>.
- Military Active Duty, Veterans or Military Active Duty Spouses must provide either a copy of Military Change of Station Orders, Identification Card or a document showing proof of Honorable or General Discharge.

## 2-Step Application and Payment process

Once TSBDE has approved your examination application, a license number will be issued. The status of your license will be expired with a future date. You will receive a letter of approval with instructions for activating your Initial renewal. The approval letter will authorize you to practice for 30 days. Once your initial renewal has been paid, you should receive your new license within 7-10 business days via mail.

**Exception:** Active duty military, veterans and active duty military spouses are not required to pay to activate their license. The license will be issued and mailed to the applicant after the application has been approved. Your first license may be valid anywhere between 6 months to 17 months. You will receive a reminder post card approximately 45 days prior to your license expiration date.

## Additional Information

**Anesthesia Permits.** Dentists must be issued a Texas Dental License before an Application for an Anesthesia Permit can be processed.

**Change of Address.** Licensees are required to notify the TSBDE within 60 days of a change in address.

**Continuing Education.** New licensees are exempt from completing CE during their first licensure period. After the first license is renewed licensees should begin collecting CE.

**CPR Requirement.** CPR Courses must include a hands-on demonstration of skills by the applicant on a manikin and a written assessment of skills.

**Foreign Language Documents.** All documents issued in a foreign language must be translated to English.