

# State Board of Dentistry

KEEP A COPY OF THIS APPLICATION  
FOR YOUR RECORDS.

## RENEWAL APPLICATION

Dentist - DS

Return to:

State Board of Dentistry  
PO Box 8417  
Harrisburg, PA 17105-8417

NAME \_\_\_\_\_

STREET ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_

LICENSE NUMBER \_\_\_\_\_

Check below if submitting a name change:

**NAME CHANGE** – Submit a photocopy of a legal document verifying the name change (i.e. marriage certificate, divorce decree or legal court issued name change)

\_\_\_\_\_  
Prior Name

\_\_\_\_\_  
Current (New) Name

### Act 31 of 2014 – Initial Training and Continuing Education in Child Abuse Recognition and Reporting Requirements

All health-related licensees and funeral directors are considered “mandatory reporters” under section 6311 of the Child Protective Services Law (CPSL) (23 P.S. §6311), as amended, that EFFECTIVE JANUARY 1, 2015, all persons applying for the renewal of a license issued by the Board shall be required to complete at least 2 hours of Board-approved continuing education in child abuse recognition and reporting requirements as a condition of renewal.

Please note that Act 31 applies to all health-related licensees, regardless of whether they are subject to the continuing education requirements of the applicable Board. Additional information regarding this requirement is posted on the Board’s website at [www.dos.pa.gov/dent](http://www.dos.pa.gov/dent).

### SECTION A - THE FOLLOWING QUESTIONS MUST BE ANSWERED – CHECK “YES” OR “NO” FOR EACH QUESTION

YES	NO	If “YES” to questions 2, 3, 4, 5, 6, 7, 8, 9, 10 and/or 11 – provide details AND attach certified copies of legal document(s).
		1. Do you hold, or have you ever held, a license, certificate, permit, registration or other authorization (active or inactive, current or expired) to practice any health-related profession in any state or jurisdiction? <b>If “Yes” List the profession and state or jurisdiction here →</b>
		2. <b>Since your initial application or your last renewal</b> , whichever is later, have you had disciplinary action taken against a professional or occupational license, certificate, permit, registration or other authorization to practice a profession or occupation issued to you in any state or jurisdiction or have you agreed to a voluntary surrender in lieu of discipline?
		3. Do you currently have any disciplinary charges pending against your professional or occupational license, certificate, permit or registration in any state or jurisdiction?
		4. <b>Since your initial application or your last renewal</b> , whichever is later, have you withdrawn an application for a professional or occupational license, certificate, permit or registration, had an application denied or refused, or for disciplinary reasons agreed not to reapply for a professional, license, certificate, permit or registration in any state or jurisdiction?
		5. <b>Since your initial application or last renewal</b> , whichever is later, have you been convicted (found guilty, plead guilty or pled contendere), received probation without verdict, accelerated rehabilitative disposition (ARD), as to any criminal charges, felony or misdemeanor, including any drug law violations? Note: You are not required to disclose any ARD or other criminal matter that has been expunged by order of a court.
		6. Do you currently have any criminal charges pending and unresolved in any state or jurisdiction?
		7. <b>Since your initial application or last renewal</b> , whichever is later, have you had your DEA registration denied, revoked or restricted?
		8. <b>Since your initial application or your last renewal</b> , whichever is later, have you had provider privileges denied, revoked, suspended or restricted by a Medical Assistance agency, Medicare, third party payor or another authority?
		9. <b>Since your initial application or your last renewal</b> , whichever is later, have you had your practice privileges denied, revoked, suspended or restricted by a hospital or any health care facility?
		10. <b>Since your initial application or your last renewal</b> , whichever is later, have you been charged by a hospital, university or research facility with violating research protocols, falsifying research or engaging in other research misconduct?
		11. <b>Since your initial application or your last renewal</b> , whichever is later, have you engaged in the intemperate or habitual use or abuse of alcohol or narcotics, hallucinogenics or other drugs or substances that may impair judgment or coordination?
		12. Have you completed 2 hours of Board-approved continuing education in child abuse recognition and reporting?
		13. Do you practice dentistry in the Commonwealth of Pennsylvania?
		14. If yes, do you maintain the required medical professional liability insurance in the minimum amount of one million dollars per occurrence or claim and three million dollars per annual aggregate?
		15. Do you practice in an office where other individuals administer general anesthesia, deep sedation or conscious sedation on your patients but you do not hold an Unrestricted or Restricted I anesthesia permit?
		16. If yes, have you completed the required five (5) hours of Board-approved courses of study related to general anesthesia, deep sedation or conscious sedation? Note: The required five (5) hours may be used towards meeting the 30 hours required for renewal of a license.



**Commonwealth of Pennsylvania  
Department of Health  
2017 Survey of Dentists**

**IF YOU HAVE ALREADY SUBMITTED YOUR RENEWAL SURVEY ONLINE, DO NOT MAIL THIS SURVEY.**

The Department of Health, with the support of the Department of State, requests that you complete this survey to assist in understanding and describing the dentist workforce. The personal data that is being requested will not be released or shared for reasons other than analysis and preparation of aggregate reports, unless the release is required by law. To view past dentist workforce reports, visit [www.health.state.pa.us/workforce](http://www.health.state.pa.us/workforce). Thank you for your cooperation!

1. Year of Birth          2. Sex  Male  Female      3. Hispanic or Latino Origin  Yes  No
4. Race (check one)  American Indian/Alaska Native  Asian  Black/African American  
 Native Hawaiian/Other Pacific Islander  White/Caucasian  Two or more races  
 Other \_\_\_\_\_
5. State of Residence (state abbreviation)    Non-US (check)      5a. County of Residence (codes on page 4)    
 If you do not live in Pennsylvania, select 00 for county not in Pennsylvania.
6. In which state did you graduate from dental school? (state abbreviation)    Non-US (check)  
 6a. In what year did you obtain this degree?
7. In which state were you first licensed as a dentist? (state abbreviation)    Non-US (check)  
 7a. In what year was this first license issued?
8. Have you completed a postdoctoral certificate program in general dentistry?  Yes  No
9. Are you board certified from the American Board of Dental Public Health?  Yes  No
- 9a. Are you board certified from the American Board of Endodontics?  Yes  No
- 9b. Are you board certified from the American Board of Oral and Maxillofacial Pathology?  Yes  No
- 9c. Are you board certified from the American Board of Oral and Maxillofacial Radiology?  Yes  No
- 9d. Are you board certified from the American Board of Oral and Maxillofacial Surgery?  Yes  No
- 9e. Are you board certified from the American Board of Orthodontics?  Yes  No
- 9f. Are you board certified from the American Board of Pediatric Dentistry?  Yes  No
- 9g. Are you board certified from the American Board of Periodontology?  Yes  No
- 9h. Are you board certified from the American Board of Prosthodontics?  Yes  No
10. What is your current training status? (check one)  Resident  Fellow  N/A  Other \_\_\_\_\_
11. In the last year, did you volunteer your services (unpaid) as a dentist in Pennsylvania?  Yes  No  
 >> **If 'No', skip to question 12.**
- 11a. In the last year, how many hours did you spend providing volunteer (unpaid) services as a dentist in Pennsylvania?
- 11b. In which location did you provide the majority of these unpaid services as a dentist in Pennsylvania? (check one)  
 Dental school clinic  Private office practice  
 Dental van  School (K-12)  
 Federally Qualified Health Center (FQHC) or health center  Other: \_\_\_\_\_
12. Select the employment status that most closely resembles your current employment status? (check one)  
 Employed in dentistry, direct or indirect  Unemployed, disabled  
 Employed not in dentistry  Unemployed, not seeking work in dentistry  
 Retired  Unemployed, seeking work in dentistry  
 Student, leave of absence, or sabbatical

**If employed in dentistry continue to question 13.**  
**If employed not in dentistry, retired, student, leave of absence, sabbatical or unemployed, you have finished the survey.**  
**Thank you!**

13. Select the employment situation that most closely resembles your **primary** employment situation. (check one)

- |  |  |
|--|--|
| <input type="checkbox"/> Administrative      | <input type="checkbox"/> Not employed as a dentist |
| <input type="checkbox"/> Direct patient care | <input type="checkbox"/> Research                  |
| <input type="checkbox"/> Education           | <input type="checkbox"/> Other _____               |

14. In a typical week, in the past 12 months, did you spend any hours providing direct patient care in Pennsylvania?

- Yes  No >> **End survey.**

If yes, indicate the number of hours you spent providing direct patient care **in Pennsylvania** during a typical week in the past 12 months

14a. **Primary** location

14b. **Secondary** location (if N/A, select 00)

Note: For the purpose of this report, direct patient care includes the amount of time a dentist spends directly with patients in a dental practice setting or patient-specific office work. This would also include “on call” hours if the dentist is required to remain in a medical/dental practice setting.

**If the answer to question 14 was “no”, do not provide direct patient care in Pennsylvania. END survey here.**

15. Do you most closely identify as a generalist or a specialist?

- Generalist >> **Skip to question 17.**  
 Specialist

16. **If you most closely identify as a specialist**, indicate the category that most closely represents specialty in which the **majority** of your dental practice time is spent. (check one)

- |  |  |                                    |
|--|--|------------------------------------|
| <input type="checkbox"/> Endodontics         | <input type="checkbox"/> Pathology           | <input type="checkbox"/> Radiology |
| <input type="checkbox"/> Geriatric Dentistry | <input type="checkbox"/> Pediatric Dentistry | <input type="checkbox"/> Other     |
| <input type="checkbox"/> Oral Surgery        | <input type="checkbox"/> Periodontics        |                                    |
| <input type="checkbox"/> Orthodontics        | <input type="checkbox"/> Prosthodontics      |                                    |

17. **If you most closely identify as a generalist**, do you practice in the following areas?

- |                          |  |                          |  |
|--------------------------|--|--------------------------|--|
| 17a. Endodontics         | <input type="checkbox"/> Yes <input type="checkbox"/> No | 17f. Pediatric Dentistry | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 17b. Geriatric Dentistry | <input type="checkbox"/> Yes <input type="checkbox"/> No | 17g. Periodontics        | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 17c. Oral Surgery        | <input type="checkbox"/> Yes <input type="checkbox"/> No | 17h. Prosthodontics      | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 17d. Orthodontics        | <input type="checkbox"/> Yes <input type="checkbox"/> No | 17i. Radiology           | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 17e. Pathology           | <input type="checkbox"/> Yes <input type="checkbox"/> No | 17j. Other               | <input type="checkbox"/> Yes <input type="checkbox"/> No |

18. The following questions (18a-18d) are requested for the purposes of identifying Dental Health Professional Shortage Areas (HPSAs).

18a. What is the address of your **primary** practice location?  Non-US (check)

18a1. Street \_\_\_\_\_

18a2. City \_\_\_\_\_

18a3. State

18a4. ZIP Code

18a5. County

(codes on page 5—if you do not practice in Pennsylvania, select 00)

18b. What is the address of your **secondary** practice location?  N/A  Non-US (check)

18b1. Street \_\_\_\_\_

18b2. City \_\_\_\_\_

18b3. State

18b4. ZIP Code

18b5. County

(codes on page 5—if you do not practice in Pennsylvania, select 00)

18c. Estimate the percentage of patients on a sliding fee scale at your **primary** practice location:

\*Required to avoid duplication  
\*Anonymous & aggregate reporting only

- I do not offer a sliding fee scale
- 0%-5%
- 11%-20%
- 31%-50%
- 6%-10%
- 21%-30%
- greater than 50%

18d. Estimate the percentage of patients on a sliding fee scale at your **secondary** practice location:

- N/A
- 0%-5%
- 21%-30%
- I do not offer a sliding fee scale
- 6%-10%
- 31%-50%
- 11%-20%
- greater than 50%

19. Do you provide general dentistry for patients with severe developmental or physical limitations or disabilities?

- Yes  No >> **If 'No', skip to question 20.**

19a. Do you use the following modalities to assist the patient?

- 19a1. General Anesthesia  Yes  No
- 19a2. Conscious/deep sedation  Yes  No
- 19a3. Behavior management  Yes  No
- 19a4. Other \_\_\_\_\_

19b. Do you provide sedation in the following locations?

- 19b1. Ambulatory or surgical facility  Yes  No
- 19b2. Hospital  Yes  No
- 19b3. Office/clinic  Yes  No
- 19b4. Other \_\_\_\_\_

20. What is the youngest age of children you regularly see in your office/clinic? (check one)

- <1 year
- 1 year
- 2 years
- 3 years
- 4 years
- 5 years and over
- Do not see children

21. Do you regularly see geriatric patients in your office/clinic?  Yes  No

22. Which organization best describes the **employer** you work for the most hours each week? (check one)

- Consulting/contractual/Locum Tenens
- Group practice
- Government – federal/state/local
- Hospital
- Health system
- Private practice – employee
- Private practice – full/part owner
- Public health organization – federal/state/local
- Urgent care center/clinic
- University/academic center
- Other – Independent organization
- N/A
- Other \_\_\_\_\_

23. Which **setting** best describes where you work the most hours each week? (Check one)

- Academic institution
- Ambulatory surgical facility
- Correctional facility
- Emergency department
- Hospital – federal/state
- Hospital
- Long-term care center
- Nursing home
- Office/clinic
- Public Health – federal/state/local
- Urgent care/convenient care
- Other \_\_\_\_\_

24. When thinking of the location where you spend the majority of your time providing direct patient care, is patient volume:

- Below capacity
- At capacity
- Exceeding capacity

25. Do you accept the following coverage plans?

25a. Medicaid  Yes  No

25a.1. If "No", why not? (check one)

- Credentialing
- Fee reimbursement
- Administrative burden
- Other

25a.2 If "Yes," estimate the percentage of Pennsylvania Medicaid patients at your **primary** practice location:

- 0%-5%
- 6%-10%
- 11%-20%
- 21%-30%
- 31%-50%
- greater than 50%

25a.3 If "Yes," estimate the percentage of Pennsylvania Medicaid patients at your **secondary** practice location:

- N/A
- 0%-5%
- 6%-10%
- 11%-20%
- 21%-30%
- 31%-50%
- greater than 50%

- 25b. Medicare supplemental insurance  Yes  No
- 25c. Children's Health Insurance Program (CHIP)  Yes  No
- 25d. Private insurance  Yes  No

26. Does your practice submit claims to insurance companies on behalf of patients?  Yes  No

27. Are you currently accepting new patients?  Yes  No >> **If 'No', skip to question 28.**

Do you accept new patients with the following coverage?

27a. Medicaid  Yes  No

27b. Medicare  Yes  No

27c. Children's Health Insurance Program (CHIP)  Yes  No

27d. Private insurance  Yes  No

27e. Uninsured  Yes  No

28. In the past 6 months, have you utilized language interpretive services to patients? (Languages other than English)

Yes  No >>**If 'No,' skip to question 29.**

28a. In which languages did you utilize language interpretive service to patients? (Check all that apply)

Arabic  Chinese  French  German  Hindi  Italian  
 Korean  Russian  Sign Language  Spanish  Urdu  Other \_\_\_\_\_

For questions 29 and 30, please consider your use of health information technology to collect, store and exchange your patients' clinical information.

29. Does your dental practice use an electronic health records (EHR) system to collect, store and retrieve your patients' clinical information?  Yes  No  Unsure

30. Does your dental practice currently have the ability to electronically exchange patients' clinical information with other providers?

Yes  No  Unsure

>>**If 'no' or 'unsure', skip to question 31.**

If yes, do you engage in the following?

30a. Sending prescriptions to pharmacies  Yes  No

30b. Sending/receiving patients' clinical information to/from other dental practices  Yes  No

30c. Sending/receiving patients' clinical information to/from physicians (primary care and/or specialists)  Yes  No

31. In the **past 12 months**, how satisfied were you with your dental career?

Very Satisfied  Satisfied  Dissatisfied  Very Dissatisfied

32. **Overall**, how satisfied are you with your dental career?

Very Satisfied  Satisfied  Dissatisfied  Very Dissatisfied

33. What is the greatest source of your professional **satisfaction**? (check one)

Decision making autonomy  Financial reasons – salary/income/benefits  Intellectual challenge  
 Patient relationships  Practice environment  Staff relationships  
 N/A — completely dissatisfied  Other: \_\_\_\_\_

34. What is the greatest source of your professional **dissatisfaction**? (check one)

Availability of leisure time  Decision making autonomy  Financial reasons – salary/income/benefits  
 Patient relationships  Practice environment  Staff relationships  
 Time spent with patients  N/A — completely satisfied  Other: \_\_\_\_\_

35. How long have you practiced dentistry in Pennsylvania?

Less than 3 years  3 to less than 6 years  6 to less than 11 years  11 to less than 16 years  16+ years

36. How much longer do you anticipate practicing dentistry in Pennsylvania?

Less than 3 years  3 to less than 6 years  6 to less than 11 years  11 to less than 16 years  16+ years

37. How much longer do you anticipate practicing direct patient care as a dentist in Pennsylvania?

Less than 3 years  3 to less than 6 years  6 to less than 11 years  11 to less than 16 years  16+ years

38. If you plan to leave direct patient care in Pennsylvania in less than 6 years, indicate your **primary** reason below (check one).

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Change careers              | <input type="checkbox"/> Financial reasons –<br>salary/income/benefits | <input type="checkbox"/> Retirement     |
| <input type="checkbox"/> Complete further training   | <input type="checkbox"/> Illness/disability                            | <input type="checkbox"/> Stress/burnout |
| <input type="checkbox"/> Dissatisfaction with career | <input type="checkbox"/> Physical demands                              | <input type="checkbox"/> Not applicable |
| <input type="checkbox"/> Family reasons              | <input type="checkbox"/> Practice demands                              | <input type="checkbox"/> Other: _____   |

## Thank you!

**If you are interested in learning more about emergency disaster response effort volunteer opportunities in Pennsylvania, please access [www.serv.pa.gov](http://www.serv.pa.gov) for more information.**

Pennsylvania County Codes						
01=Adams	11=Cambria	21=Cumberland	31=Huntingdon	41=Lycoming	51=Philadelphia	61=Venango
02=Allegheny	12=Cameron	22=Dauphin	32=Indiana	42=McKean	52=Pike	62=Warren
03=Armstrong	13=Carbon	23=Delaware	33=Jefferson	43=Mercer	53=Potter	63=Washington
04=Beaver	14=Centre	24=Elk	34=Juniata	44=Mifflin	54=Schuylkill	64=Wayne
05=Bedford	15=Chester	25=Erie	35=Lackawanna	45=Monroe	55=Snyder	65=Westmoreland
06=Berks	16=Clarion	26=Fayette	36=Lancaster	46=Montgomery	56=Somerset	66=Wyoming
07=Blair	17=Clearfield	27=Forest	37=Lawrence	47=Montour	57=Sullivan	67=York
08=Bradford	18=Clinton	28=Franklin	38=Lebanon	48=Northampton	58=Susquehanna	
09=Bucks	19=Columbia	29=Fulton	39=Lehigh	49=Northumberland	59=Tioga	00=Not in PA
10=Butler	20=Crawford	30=Greene	40=Luzerne	50=Perry	60=Union	

**PART - SECTION B - Continuing Education – SELECT ONE BELOW.** You are required to maintain certificates for a minimum of 4 years after completion of the program. Do not submit any certificates or proof of completion to the Board. The Board will be conducting a random audit and you will be required to supply them to the Board upon request.

- I have attended/completed the required **30 credit hours** of continuing education during the period from April 1, 2015 to March 31, 2017 in acceptable courses obtained through approved programs sponsors with no more than 50% of the credits obtained through individual study.  
**NOTE:** CPR cannot be counted towards fulfillment of the continuing education credit hours required.
- I wish to claim exemption from the continuing education requirements because my initial certificate was issued between April 1, 2015 and March 31, 2017. (No exemption from Act 31 requirement outlined above.)
- I have received **written approval from the Board** for an extension or waiver of the required continuing education based on illness, emergency or hardship.

**NOTE:** Indicating that you completed the required continuing education hours if you have not, subjects you to disciplinary and criminal action for **BOTH** failure to complete the requirements **AND** for falsifying a renewal.

**SECTION D – VERIFICATION OF INFORMATION**

By signing below, I verify that this form is in the original format as supplied by the Department of State and has not been altered or otherwise modified in any way. I am aware of the criminal penalties for tampering with public records or information pursuant to 18 Pa. C.S.§4911.

Additionally, I verify that the statements in this application are true and correct to the best of my knowledge, information and belief, and that I am of good moral character. I understand that any false statement made is subject to the penalties of 18 Pa. C.S.§4904 relating to unsworn falsification to authorities and may result in the suspension, revocation or denial of my license, certificate, permit or registration.

**Signature of Certificate Holder (Mandatory):** \_\_\_\_\_ **Date:** \_\_\_\_\_

**INACTIVE STATUS**

If you will not be practicing dentistry in Pennsylvania after March 31, 2017, you may place your certificate on inactive status by checking the box below. The form must be completed in its entirety. **No fee, CPR certification or continuing education is required to maintain inactive status.**

- I **will not** be practicing dentistry in Pennsylvania after March 31, 2017.

<b>EXPIRATION DATE: →</b>	<b>March 31, 2017</b> <b>NOTE: Upon renewal the license will expire March 31, 2019</b>
<b>FEE – Payable to “COMMONWEALTH OF PENNSYLVANIA” →</b>	<b>\$263.00</b>
<p>Write your license number on your payment. <i>A \$20.00 fee will be assessed for returned payments.</i></p> <p><b>LATE FEE – a \$5.00 per month, or part of a month will be assessed if postmarked AFTER 03-31-17</b></p> <p><b>PRACTICING ON AN EXPIRED LICENSE MAY RESULT IN DISCIPLINARY ACTIONS AND ADDITIONAL MONETARY PENALTIES</b></p> <p><b>TO ENSURE YOU RECEIVE YOUR NEW LICENSE BEFORE IT EXPIRES</b></p> <p><b>RETURN BY: MARCH 1, 2017</b></p>	