Dentistry License Application Packet

Contents:

Important Social Security Number Information:

If you have a Social Security Number, the law requires you to disclose it on your application for a professional or occupational license. 42 U.S.C. § 666(a)(13); RCW 26.23.150. It will be used under the state's child support enforcement program to locate individuals for purposes of establishing paternity and establishing, modifying, and enforcing support obligations. You are not required to have or obtain a Social Security Number to apply for or obtain a license from the Department of Health. If you do not have a Social Security Number, you are still eligible to apply for and obtain a credential if you meet the requirements. Please see the Declaration of No Social Security Number Form. Please call the Customer Service Center at 360-236-4700 if you have questions.

In order to process your request:

Mail your application with initial documentation and your check or money order payable to:

Department of Health
P.O. Box 1099
Olympia, WA 98507-1099

Send other documents not sent with initial application to:

Dental Quality Assurance Commission
Credentialing
P.O. Box 47877
Olympia, WA 98504-7877

Contact us:

360-236-4700

To request this document in another format, call 1-800-525-0127. Deaf or hard of hearing customers, please call 711 (Washington Relay) or email **civil.rights@doh.wa.gov.**

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Application Instructions Checklist

Important background check Information: Washington State law authorizes the Department of Health to obtain fingerprint-based background checks for licensing purposes. This check may be through the Washington State Patrol and the Federal Bureau of Investigation (FBI). This may be required if you have lived in another state or if you have a criminal record in Washington State. This would be at your own expense.

All information should be printed clearly in blue or black ink. It is your responsibility to submit the required forms.

☐ **Application Fee**. This fee is non-refundable. You can check the online fee page for current fees.

☐ **Check if either apply:**
Request for Military Training and Experience Evaluation
Spouse or Registered Domestic Partner of Military Personnel

☐ **1. Demographic Information:**
Social Security Number: You must list your social security number on your application. You are not required to have or obtain a Social Security Number to apply for or obtain a license from the Department of Health. Please see the Declaration of No Social Security Number Form. Please call the Customer Service Center at 360-236-4700 if you do not have one.

National Provider Identifier Number (NPI): The National Provider Identifier (NPI) is a standard unique identifier for health care professionals available from the Federal Centers for Medicare and Medicaid Services. The NPI is a 10 digit numeric identifier. If you have a NPI number, provide this on your application.

Legal Name: List your full name: first, middle, and last.

Definition of legal name: "Legal name" is the name appearing on your official certificate of birth or, if your name has changed since birth, on an official marriage certificate or an order by a court. The court must have the legal authority to change your name. We may ask you to prove your legal name. If you use any name other than your legal name on this form, your application may be denied.

Birth date: Provide the month, day, and year of your birth.

Address: List the address we should use to send any information on your license. Be sure to include the city, state, zip code, county, and country. This will be your permanent address with the Department of Health until we have been notified of a change. See WAC 246-12-310.

Phone, Fax and Cell Numbers: Enter your phone, fax and cell numbers.
Email: Enter your email address, if you have one.

Other Name(s): Indicate whether you are known or have been known under any other names. If you have a name change, you must notify the Department of Health in writing. You must include proof of this change. See WAC 246-12-300.

☐ **2. Personal Data Questions:**
All applicants must answer the same personal data questions. They are focused on your fitness to practice the essential skills of this profession.

If you answer "yes" to any questions in this section, you must provide an appropriate explanation. You must also provide the documentation listed in the note after the question. If you do not provide this, your application is incomplete and it will not be considered.

- Question 5 includes misdemeanors, gross misdemeanors and felonies. You do not have to answer yes if you have been cited for traffic infractions. You can get copies of court records through the county courthouse where the conviction, plea, deferred sentence, or suspended sentence was entered.
- If you have been granted certificate(s) of restoration of opportunity, please provide a certified copy of each certificate.
- Another jurisdiction means any other country, state, federal territory, or military authority.

☐ **3. Training and Experience:**
Please list in date order all professional work experience. Include all periods of time from the date of graduation from dental school to present whether or not engaged in activities related to dentistry. Attach additional pages if you need more space.

☐ **4. Malpractice Clearance:**
Applicants must have all malpractice carriers submit a letter verifying dates of coverage and any claims history. In the event of a claims history, appropriate legal documentation must also be submitted. If coverage is provided via an umbrella policy through a school, or if you are practicing in the military, please indicate in writing.

☐ **5. DEA:**
List your DEA # if you have one.

☐ **6. Clinical Examination:**
Select all the dental clinical examinations you have taken or if you have completed a qualifying residency. If you have completed a residency, please complete the Residency Verification Form.

☐ **7. Written Examination:**
Select all the dental written examinations you have taken.

☐ **8. Other License, Certification, or Registration:**
List all states, including Washington, where credentials are or were held. Attach additional completed pages if you need more space. You must also print the Verification Form and provide it to each state or jurisdiction that you have listed, requesting that they complete and submit the form directly to the Department of Health.

☐ **9. Applicant's Photograph:**
Attach a current photograph in the box provided or attach it to the application. Indicate date the photograph was taken and sign in ink across the bottom of the photo. The photograph must be a clear, close up and a front view. Your application will not be processed without a current photograph.

☐ **10. Applicant's Attestation:**
You must sign and date this for us to process the application.

For Spouses and Registered Domestic Partners of Military Personnel Being Transferred or Stationed in Washington:

Under state law, if you are the spouse or state-registered domestic partner of a servicemember of any branch of the U.S. Military, to include Guard or Reserve, and are applying for a health care professional credential in this state, you may be eligible to have the processing of your application expedited to receive your credential more quickly.

Documents to submit with your application should include the following:

- A copy of your spouse's or registered domestic partner's military transfer orders to Washington State.
- One of the following:
  - A copy of your marriage certificate to show proof of marriage; or
  - A copy of a state's declaration or registration showing you are in a state registered domestic partnership with a member of the U.S. military.

For Current and Former Servicemembers Requesting Evaluation of Military Training and Experience

Under state law, your military education, training, and experience may count towards attaining certain civilian health care profession credentials in Washington State.

Submitted information will be reviewed by the Department of Health to determine substantial equivalency for meeting the credentialing requirements in this state.

Documents to submit with your health care professional credential application should include the following:

- If applicable, a copy of your DD214 Certificate of Release or Discharge from Active Duty, Member-4 or service 2 copy, or NGB-22 for National Guard.

  Please note:
  - A copy of your DD214 can be downloaded from the EBenefits website.
  - You can request a replacement copy of your NGB-22 on the National Archives website.
- Official Joint Service Transcript (JST) or Community College of the Air Force(CCAF) Transcripts.

  Please note:
  - JST can be sent electronically by visiting the JST website and selecting Washington State Department of Health.
  - CCAF transcripts cannot be sent electronically. See the CCAF website for transcript information.
- Verification of Military Experience and Training (VMET) or DD Form 2586. See the DoDTAP website.
- If applicable, application for the Evaluation of Learning Experiences During Military Service (DD Form 295). See the Military Resources website.

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License Requirements

Thank you for applying to become a licensed dentist in Washington State.
The following items will need to be sent in directly to the department from the primary source to the address listed above.

☐ **Transcript (with degree posted)**
Graduates from a Commission on Dental Accreditation (CODA) dental school must submit official transcripts with dental degree posted. Graduates from a non approved dental school must submit official school transcript or diploma with dental degree listed to include the date of graduation transcribed into English if necessary. Non-posted transcripts or student copies are not acceptable. Transcripts must be sent to the department directly from your dental school.

☐ **Jurisprudence Examination**

Complete the online examination. Once you have successfully completed the examination, your electronic results will be submitted to the Department. Please print the results page for your records. It is a multiple choice exam and designed to familiarize you with the Washington State dentistry laws.

☐ **DEA**

Complete this form if you have ever had a DEA number and submit it directly to the Drug Enforcement Administration in Seattle. To contact the Seattle DEA, call 1-888-219-1418. If you have not had a DEA number please complete the attestation on the application.

☐ **Other License, Certification, or Registration**
Credential verifications must be requested by the applicant and submitted directly from every state.

Note: Many states charge a verification processing fee. Contact them prior to request to prevent delays in processing.

☐ **Malpractice Clearance**
Applicants must have malpractice carriers submit a letter verifying dates of coverage and any claims history. In the event of a claims history, appropriate legal documentation must also be submitted. If coverage is provided via an umbrella policy through a school, or if you are practicing in the military, please indicate in writing.

☐ **Military/Commanding Officer Letter**
If applicant is on active duty in the military, a letter must be submitted from the commanding officer outlining duties, length of service and whether any adverse actions have been reported or taken.

License by Examination

If you are applying license by examination, you must also meet the requirements listed below. Verification of your examination scores sent electronically or directly from an approved examination organization or a notarized copy of the original examination scores must be submitted. We will attempt to obtain examination scores online through the examination organization if available. Please make sure all examination information is entered under the Clinical and Written Examination sections of the application.

☐ **Written Examination Scores**

- **Integrated National Board Dental Examination**

  Joint Commission on National Dental Examinations
  211 East Chicago Avenue,
  Suite 1846
  Chicago, Illinois 60611
  1-800-621-8099

- **National Board Scores (Part I and II)**
  Joint Commission on National Dental Examinations
  211 East Chicago Avenue, Suite 1846
  Chicago, Illinois 60611
  1-800-621-8099

- **Canadian National Board Scores**
  The National Dental Examining Board of Canada
  80 Elgin Street, 2nd Floor
  Ottawa, Ontario, Canada K1P 6R2
  613-236-5912

☐ **Clinical Examination Scores**

Verification of your examination scores sent directly from an approved examination organization or a notarized copy of the original examination scores must be submitted. Examination results will be accepted for up to five years preceding your application to Washington State. See WAC 246-817-120. The regional examining boards may charge a processing fee for verification. Verification should be requested directly from the regional examining board. If you need to take the examination, applications for the examination should be requested directly from one of the following:

- Western Regional Examining Board (WREB) at 602-944-3315
- Central Regional Dental Testing Service (CRDTS) at 785-273-0380
- Southern Region Testing Agencies (SRTA) at 757-318-9082
- Commission on Dental Competency Assessments (CDCA) formally known as NERB at 301-563-3300 ext. 227
- Council of Interstate Testing Agency's (CITA) at 1-866-678-9795.
- National Dental Examining Board (NDEB) of Canada at 613-236-5912 (must be a graduate of an approved dental school).
- Joint Commission on National Dental Examination's Dental Licensure Objective Structured Clinical Examination (DLOSCE)

OR

☐ **Completion of a qualifying postgraduate residency program.**
In lieu of the practical examination, you may provide proof that you have completed a general practice residency, pediatric residency, or advanced education in a general dentistry residency program that is located in Washington State and accredited by the Commission on Dental Accreditation of the American Dental Association. Your residency must be at least one year in a program that serves predominantly low-income patients.

Submit the Residency Verification Form as proof of completion.

Additional Educational Requirements Graduates of Non Approved Dental Schools

Graduates of non approved dental schools must meet the additional education requirements outlined in WAC 246-817-160, which includes at least two additional predoctoral or postdoctoral academic years of a CODA accredited dental program.

License without Examination

If you are applying by license without examination, you must also meet the requirements listed below.

☐ **Licensed in another state**

- Hold an active dentist license in another U.S. State or territory; and
- Are currently engaged in the practice of dentistry. See WAC 246-817-135

☐ **Proof of type of dentistry practice**

- Complete the Proof of Practice form, which includes type of dentistry practice, address at your practice location(s), length of time at the location(s) and federal or state tax numbers.
  - If you are a dentist practicing dentistry for a minimum of 20 hours per week for the four consecutive years preceding this application in another U.S. state or territory.
  - If you are a dentist serving in the United States federal services (see RCW 18.32.030(2)), please also submit a letter from the commanding officer outlining duties, length of service and whether any adverse actions have been reported or taken.
  - If you are a dentist employed by a dental school (see WAC 246-817-110(2)(a)), please also submit documentation from the dean or the appropriate administrator of the institution regarding the length, terms of employment, responsibilities and any adverse actions or restrictions.
  - If you are a dentist in a dental residency program, please also submit

documentation from the director or the appropriate administrator of the residency program regarding the length of the residency, duties and responsibilities and any adverse actions or restrictions.

Additional Educational Requirements Graduates of Non Approved Dental Schools

Graduates from a non approved dental school must meet the requirements under RCW 18.32.215 which requires graduates of non-CODA accredited schools to complete a CODA accredited one-year postdoctoral residency and hold an active dentist license in another state for at least four years if applying by license without examination.

You will be notified in writing if further documentation is required.

- The initial license will expire on your birthday unless the license is issued within 90 days of your next birthday. See WAC 246-12-020 (3).
- You will receive a courtesy renewal notice if your address of record is kept up to date. Any renewal postmarked or presented to the department after midnight on the expiration date is late.

Note: You cannot practice dentistry until your license is issued.

Date Stamp Here

Rev 0251030000

Dentist Application

Select One: ☐ License by Exam Via: ☐ Clinical Examination ☐ Residency in Lieu of Exam
☐ License without Exam

Select if either apply: ☐ Request for Military Training and Experience Evaluation
☐ Spouse or Registered Domestic Partner of Military Personnel

1. Demographic Information

Social Security Number (SSN) (If you do not have a SSN, see instructions)	**National Provider Identifier Number (NPI)** (Enter 10 digit number)	☐ Male ☐ Female ☐ Prefer Not to Answer ☐ X

Name First Middle Last

Birth date (mm/dd/yyyy)

Address

City	State	Zip Code	County

Country

Phone (enter 10 digit #)	Fax (enter 10 digit #)	Cell (enter 10 digit #)

Email address

Mailing address if different from above address of record

City	State	Zip Code	County

Country

Note: The mailing and email addresses you provide will be your addresses of record. It is your responsibility to maintain current contact information with the department.

Have you ever been known under any other name(s)? ☐ Yes ☐ No
If yes, list name(s):

Will documents be received in another name? ☐ Yes ☐ No
If yes, list name(s):

Dental School

2. Personal Data Questions

Yes No

1. Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please attach explanation. ☐ ☐

   "Medical Condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, intellectual disabilities, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction, and alcoholism.

   If you answered yes to question 1, explain:

   1a. How your treatment has reduced or eliminated the limitations caused by your medical condition.

   1b. How your field of practice, the setting or manner of practice has reduced or eliminated the limitations caused by your medical condition.

> **Note: If you answered "yes" to question 1, the licensing authority will assess the nature, severity, and the duration of the risks associated with the ongoing medical condition and the ongoing treatment to determine whether your license should be restricted, conditions imposed, or no license issued.**
>
> **The licensing authority may require you to undergo one or more mental, physical or psychological examination(s). This would be at your own expense. By submitting this application, you give consent to such an examination(s). You also agree the examination report(s) may be provided to the licensing authority. You waive all claims based on confidentiality or privileged communication. If you do not submit to a required examination(s) or provide the report(s) to the licensing authority, your application may be denied.**

2. Do you currently use chemical substance(s) in any way which impair or limit your ability to practice your profession with reasonable skill and safety? If yes, please explain. ☐ ☐

   "Currently" means within the past two years.

   "Chemical substances" include alcohol, drugs, or medications, whether taken legally or illegally.

3. Have you ever been diagnosed with, or treated for, pedophilia, exhibitionism, voyeurism or frotteurism? ☐ ☐

4. Are you currently engaged in the illegal use of controlled substances? ☐ ☐

   "Currently" means within the past two years.

   Illegal use of controlled substances is the use of controlled substances (e.g., heroin, cocaine) not obtained legally or taken according to the directions of a licensed health care practitioner.

> **Note: If you answer "yes" to any of the remaining questions, provide an explanation and certified copies of all judgments, decisions, orders, agreements and surrenders. The department does criminal background checks on all applicants.**

5. Have you **ever** been convicted, entered a plea of guilty, no contest, or a similar plea, or had prosecution or a sentence deferred or suspended as an adult or juvenile in any state or jurisdiction? ☐ ☐

> **Note: If you answered "yes" to question 5, you must send certified copies of all court documents related to your criminal history with your application. If you do not provide the documents, your application is incomplete and will not be considered.**
>
> **If you have been granted certificate(s) of restoration of opportunity, please provide a certified copy of each certificate.**
>
> **To protect the public, the department considers criminal history. A criminal history may not automatically bar you from obtaining a credential. However, failure to report criminal history may result in extra cost to you and the application may be delayed or denied.**

2. Personal Data Questions (cont.)

	Yes	No
6. Have you ever been found in any civil, administrative or criminal proceeding to have:		
a. Possessed, used, prescribed for use, or distributed controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes?	☐	☐
b. Diverted controlled substances or legend drugs?	☐	☐
c. Violated any drug law?	☐	☐
d. Prescribed controlled substances for yourself?	☐	☐
7. Have you ever been found in any proceeding to have violated any state or federal law or rule regulating the practice of a health care profession? If "yes", please attach an explanation and provide copies of all judgments, decisions, and agreements?	☐	☐
8. Have you ever had any license, certificate, registration or other privilege to practice a health care profession denied, revoked, suspended, or restricted by a state, federal, or foreign authority?	☐	☐
9. Have you ever surrendered a credential like those listed in number 8, in connection with or to avoid action by a state, federal, or foreign authority?	☐	☐
10. Have you ever been named in any civil suit or suffered any civil judgment for incompetence, negligence, or malpractice in connection with the practice of a health care profession?	☐	☐
11. Have you ever been disqualified from working with vulnerable persons by the Department of Social and Health Services (DSHS)?	☐	☐

3. Training and Experience

List in date order all of your professional education and experience pertaining to the profession for which you are making application. Include all periods of time from the date of graduation from dental school to present whether or not engaged in activities related to dentistry. You do not have to list continuing education courses. Attach additional pages if you need more space.

Dates		Name and address of institute, place of practice.	Degree/certificate and date received Type of experience or specialty
From (mm/dd/yyyy)	To (mm/dd/yyyy)		

4. Malpractice Clearance

Do you have Malpractice Coverage? ☐ Yes ☐ No

Please provide the name of your malpractice insurance carrier: _____

If yes, have your malpractice carrier submit a letter verifying dates of coverage and any claims history. In the event of a claims history, appropriate legal documentation must also be submitted.

Is your coverage provided via an umbrella policy through a school? ☐ Yes ☐ No

Is your coverage provided via the military? ☐ Yes ☐ No

If your coverage is via an umbrella policy through a school or provided by the military, please indicate that by attesting.

Applicant's Initials	Date

5. DEA

Do you have a DEA number? ☐ Yes ☐ No
If yes, list your DEA number and submit the DEA Authorization form.

DEA #_____

If no, please indicate that by attesting.

I certify that I have never obtained a DEA number.

Applicant's Initials	Date

6. Clinical Examination

The clinical examinations listed below are the approved clinical examinations for licensure.
Select the clinical examinations that you have taken.

☐ Western Regional Examining Board (WREB). Date of exam:_____

☐ Central Regional Dental Testing Service (CRDTS). Date of exam:_____

☐ Southern Regional Testing Agency (SRTA). Date of exam: _____

☐ Commission on Dental Competency (CDCA) formally known as NERB. Date of exam:_____

☐ Council of Interstate Testing Agency (CITA). Date of exam: _____

☐ National Dental Examining Board (NDEB) of Canada. Date of exam: _____
(Must be a graduate of an approved dental school).

☐ Joint Commission on National Dental Examination's Dental Licensure Objective Structured Clinical Examination (DLOSCE). Date of exam: _____

☐ Examination results of a U.S. state or territory with an individual state board clinical examination.
Date of exam: _____

☐ Completion of a qualifying postgraduate residency program.
Postgraduate Residency Program Name: _____
Please complete the Residency Verification form and return it to the department. See RCW 18.32.040.

7. Written Examination:

The written examinations listed below are the approved written examinations for licensure.
Select the written examinations that you have taken.

☐ Integrated National Board Examination. Date of exam: _____

☐ National Board Dental Examination Parts I. Date of exam: _____

☐ National Board Dental Examination Parts II. Date of exam: _____

☐ The Canadian National Dental Examining Board examination. Date of exam: _____

8. Other License, Certification, or Registration

List all states where credentials are or were held. Please list all active, inactive and expired credentials. Specifically list credentials granted as temporary, reciprocity, exemption or similar with type, date, grantor, and if credential is current. Attach additional pages if you need more space.

State	Profession	Certificate		Permanent or Temporary	License received by		Currently in force
		Year issued	Number		Examination	Other	
				☐ Perm ☐ Temp			☐ No ☐ Yes
				☐ Perm ☐ Temp			☐ No ☐ Yes
				☐ Perm ☐ Temp			☐ No ☐ Yes
				☐ Perm ☐ Temp			☐ No ☐ Yes

9. Applicant's Photograph

Photo Here

Attach Current Photograph Here. Indicate Date Taken and Sign in Ink Across Bottom of the Photo.

NOTE: Photograph **Must** Be:

1. Original, not a photocopy
2. No larger than 2" X 2"
3. Taken within one year of application
4. Close up, front view—not profile
5. Instant Polaroid Photographs **not** acceptable

10. Applicant's Attestation

I, _____ , declare under penalty of perjury under the laws of
(Print applicant name clearly)
the state of Washington that the following is true and correct:

- I am the person described and identified in this application.
- I have read RCW 18.130.170 and RCW 18.130.180 of the Uniform Disciplinary Act.
- I have answered all questions truthfully and completely.
- The documentation provided in support of my application is accurate to the best of my knowledge.
- I have read all laws and rules related to my profession.

I understand the Department of Health may require more information before deciding on my application. The department may independently check conviction records with state or federal databases.

I authorize the release of any files or records the department requires to process this application. This includes information from all hospitals, educational or other organizations, my references, and past and present employers and business and professional associates. It also includes information from federal, state, local or foreign government agencies.

I understand that I must inform the department of any past, current or future criminal charges or convictions. I will also inform the department of any physical or mental conditions that jeopardize my ability to provide quality health care. If requested, I will authorize my health providers to release to the department information on my health, including mental health and any substance abuse treatment.

By: _____ Date_____
(Original Signature of applicant) (mm/dd/yyyy)

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Dental Quality Assurance Commission
Credentialing
P.O. Box 47877
Olympia, WA 98504-7877
360-236-4700

Proof of Practice

Demographics:

Name: First Middle Last

Washington Credential #, if applicable

Date of Birth

Location of Practice

☐ I certify that I am in the practice of dentistry at the following location, I further certify I have practiced dentistry, as defined in RCW 18.32.020, for at least a minimum of twenty hours per week for the four years proceeding this application in another U.S. State or territory.

Business Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

From: _____ to _____
(mm/dd/yyyy) (mm/dd/yyyy)

Note: Please complete an additional form(s) for each location worked within the last 4 years.

Federal Tax No: _____ State Tax No: _____

☐ I certify that I am a dentist serving in the United States federal services. I will submit a letter from my commanding officer outlining my duties, length of service and whether any adverse actions have been reported or taken.

☐ I certify that I am a dentist employed by a dental school, I will submit documentation from the dean or the appropriate administrator of the institution regarding the length, terms of employment, responsibilities and any adverse actions or restrictions.

☐ I certify that I am a dentist in a dental residency program, I will submit documentation from the director or the appropriate administrator of the residency program regarding the length of the residency, duties and responsibilities and any adverse actions or restrictions.

Applicant's Signature: _____ Date: _____

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Dental Quality Assurance Commisson
PO Box 47877
Olympia, WA 98504-7877
360-236-4700

DEA Authorization

Applicant: Please complete the identifying information and submit this form directly to:

Drug Enforcement Administration
Attention: Diversion Unit, Registration
300 5th Ave Ste 1300
Seattle, WA 98104

Applicant Demographics		
First Name	Middle	Last Name
Credential # (if applicable)	Date of Birth	

Applicant Statement
I am applying for a license to practice dentistry in the state of Washington. Please send this form directly to the Dental Quality Assurance Commission Credentialing Section.
DEA Registration Number
DEA Registration Number
DEA Registration Number
DEA Registration Number
If you have additional DEA Registration Numbers, please attach another form. Applicant's Signature _____ Date _____

To be completed by the Drug Enforcement Administration
Applicant has surrendered (for cause) or had a federal controlled substance registration revoked, suspended, restricted, or denied. ☐ Yes ☐ No Initials _____ Date _____ Please mail this completed form to the Dental Quality Assurance Commission Credentialing section at the address listed above, or you can email it to: HSQAReviewDental@doh.wa.gov

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Dental Quality Assurance Commission
Credentialing
P.O. Box 47877
Olympia, WA 98504-7877
360-236-4700

Residency Verification

Please complete the top section of this form and send it to the residency program.
This form must be submitted to the Department of Health directly from the residency program.

Demographics: To be completed by the applicant		
Name First Middle Last		
Washington Credential #, if applicable	Date of Birth	
Address		
City	State	Zip Code

Applicant's Signature _____ Date _____

Residency Verification: To be completed by the residency program

I certify that the above named applicant completed a qualifying residency program.

The completed residency program met the following requirements:

- Residency Type:
  - ☐ General practice residency;
  - ☐ Pediatric residency; Or
  - ☐ Advanced education in a general dentistry
- The residency was located in Washington State and was accredited by the Commission on Dental Accreditation of the American Dental Association.
- The residency was at least one year
- The residency was a program that served predominantly low-income patients.

Residency Name		
Residency Address		
City	State	Zip Code
Start Date (mm/dd/yyyy)	End Date (mm/dd/yyyy)	

_____
Name of director of dental residency program

_____ _____
Signature of director of dental residency program Date (mm/dd/yyyy)

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RCW/WAC and Online Web Site Links

RCW/WAC Links

Uniform Disciplinary Act, RCW 18.130

Administrative Procedure Act, RCW 34.05

Administrative Procedures and Requirements, WAC 246-12

Standard of Professional Conduct Rules, WAC 246-16

Dental Professionals Laws, RCW 18.260

Dentistry Rules, WAC 246-817

Dentistry Laws, RCW 18.32

Online

Dental Quality Assurance Commission, Web page

Drug Enforcement Administration (DEA), www.deadiversion.usdoj.gov

Washington State Dental Association, www.wsda.org/

American Dental Association (ADA), www.ada.org/

Get important information about your credential type by subscribing to email alerts.

Required Continuing Education

Continuing education (CE) Training after license has been issued, WAC 246-817-440