SPOA 1102 (Rev. 10/08)

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF STATE
BUREAU OF PROFESSIONAL AND OCCUPATIONAL AFFAIRS
STATE BOARD OF DENTISTRY
P.O. BOX 2649
HARRISBURG, PA 17105-2649

Telephone: 717-783-7162 Website: www.dos.state.pa.us/dent
Facsimile: 717-787-7769 Email: st-dentistry@state.pa.us

INSTRUCTIONS FOR FILING NOTIFICATION

1. NOTIFICATION MUST BE SUBMITTED PRIOR TO BECOMING A FACULTY MEMBER OR ENTERING A POST-GRADUATE PROGRAM. EMPLOYMENT AS A FACULTY MEMBER OR POST-GRADUATE TRAINING MAY NOT BEGIN PRIOR TO RECEIVING APPROVAL FROM THE BOARD. APPROVAL WILL NOT BE GRANTED UNTIL THE APPLICATION IS COMPLETE.

2. APPLICANT MUST SUBMIT A $25.00 CHECK OR MONEY ORDER PAYABLE TO THE "COMMONWEALTH OF PA". DO NOT SEND CASH. FEES ARE NON-REFUNDABLE. NOTE: A $20.00 PROCESSING FEE WILL BE ASSESSED FOR ANY PAYMENT RETURNED BY YOUR BANK, REGARDLESS OF THE REASON FOR NON-PAYMENT.

3. THE DENTAL SCHOOL WHERE YOU OBTAINED YOUR DDS/DMD DEGREE MUST COMPLETE CERTIFICATION OF GRADUATION, BE SIGNED BY THE PROPER OFFICIAL OF THE SCHOOL, CONTAIN THE SEAL OF THE DENTAL SCHOOL AND BE SENT DIRECTLY FROM THE SCHOOL IN AN OFFICIAL DENTAL SCHOOL ENVELOPE. (PAGE 3 MAY NOT BE COMPLETED OR SUBMITTED PRIOR TO GRADUATION. PHOTOCOPIES WILL NOT BE ACCEPTED.)

4. IF APPLYING TO BECOME A FACULTY MEMBER, A LETTER OF GOOD STANDING MUST ALSO BE SENT **DIRECTLY** FROM EACH STATE OR COUNTRY WHERE YOU HOLD/HELD A LICENSE TO PRACTICE DENTISTRY. CURRENT UNRESTRICTED LICENSURE IN ANOTHER STATE OR COUNTRY IS REQUIRED FOR APPROVAL.

NOTE:

1. ACT 160 ALLOWS FOR "THE PRACTICE OF DENTISTRY BY A DULY LICENSED PRACTITIONER OF DENTISTRY OF ANY OTHER STATE OR COUNTRY FOR THE LIMITED PURPOSE OF TEACHING, INCLUDING CLINICAL TEACHING, IN A DENTAL SCHOOL OR ADVANCED DENTAL EDUCATION PROGRAM IN THE COMMONWEALTH APPROVED BY THE BOARD AFTER NOTIFICATION TO THE BOARD AND IN ACCORDANCE WITH THE BOARD REGULATIONS. APPPOINTMENTS SHALL NOT EXCEED FOUR (4) YEARS AND MAY ONLY BE EXTENDED IF THE PRACTITIONER RECEIVES A LICENSE FROM THE BOARD".

2. ACT 160 ALSO ALLOWS FOR "THE PRACTICE OF DENTISTRY IN A DENTAL CLINIC OPERATED NOT FOR PROFIT FOR THE DURATION OF AN INTERSHIP, RESIDENCY OR OTHER GRADUATE TRAINING PROGRAM APPROVED BY THE AMERICAN DENTAL ASSOCIATION COMMISSION ON DENTAL ACCREDITATION OR A DENTAL ANESTHESIOLOGY TRAINING PROGRAM THAT MEETS THE STANDARDS OF AN ACCREDITING BODY ACCEPTABLE TO THE BOARD, BY PERSONS HAVING ACQUIRED THE PRELIMINARY AND PROFESSIONAL EDUCATION REQUIRED FOR ADMISSION INTO THE PROGRAM, AFTER NOTIFICATION TO THE BOARD".

3. IT IS YOUR RESPONSIBILTY TO MAINTAIN A COPY OF THE APPLICATION AND ALL DOCUMENTS SUBMITTED TO THE BOARD OR RECEIVED FROM THE BOARD FOR YOUR FUTURE REFERENCE. PLEASE ALLOW AT LEAST 2-4 WEEKS FOR PROCESSING OF YOUR APPLICATION. INCOMPLETE APPLICATIONS WILL CAUSE DELAY IN THE ISSUANCE OF YOUR APPROVAL.

4. IF AN INDIVIDUAL HOLDS A CURRENT LICENSE TO PRACTICE DENTISTRY IN PENNSYLVANIA, THIS APPLICATION IS NOT REQUIRED.

5. SHOULD THE APPLICATION NOT BE COMPLETED WITHIN SIX MONTHS, UPDATED DOCUMENTATION MAY BE REQUIRED. ADDITIONALLY, IF THE APPLICATION PROCESS HAS NOT BEEN COMPLETED WITHIN ONE YEAR FROM THE DATE IT WAS RECEIVED, APPLICANTS WILL BE REQUIRED TO SUBMIT AN UPDATED APPLICATION-PROCESSING FEE.

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Courier Delivery Address:
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2601 NORTH THIRD STREET
HARRISBURG, PA 17110

APPLICATION FOR NOTIFICATION AND APPROVAL OF POST-GRADUATE TRAINING/FACULTY MEMBER STATUS

CHECK ONE: _____ **Post-graduate Training** _____ **Faculty Member**

1. NAME ____
   Last First Middle

2. ADDRESS ____
   Street
   ____
   City State Zip Code

3. DATE OF BIRTH ______________________________
   Month Day Year

4. SOCIAL SECURITY NUMBER ________ - ________ - ________

5. NAME OF DENTAL SCHOOL FROM WHICH YOU GRADUATED YEAR OF GRADUATION

   ______________________________________ ________________

6. LIST ALL STATES, TERRITORIES OR COUNTRIES WHERE YOU HOLD A LICENSE TO PRACTICE DENTISTRY (ACTIVE OR INACTIVE, CURRENT OR EXPIRED).

   ____

7. NAME AND ADDRESS OF THE HOSPITAL OR DENTAL SCHOOL IN PENNSYLVANIA WHERE YOU WILL RECEIVE POSTGRADUATE TRAINING OR BECOME A FACULTY MEMBER.

   ____

   ____

8. LIST THE TRAINING PROGRAM/DEPARTMENT YOU WILL BE ENTERING

   ____

9. LIST BEGINNING AND ENDING DATES OF TRAINING PROGRAM/FACULTY APPOINTMENT.

_______________________	_______________________
(Beginning Date) (Month, Day and Year)	(Ending Date) (Month, Day and Year)

10. HAVE YOU COMPLETED ANY PRIOR DENTAL INTERNSHIP/RESIDENCY TRAINING PROGRAMS?

YES _____ NO_____

IF YES, LIST THE NAME(S), LOCATION(S) AND DATE(S) OF COMPLETED TRAINING. **(TO BE COMPLETED FOR POSTGRADUATE TRAINING ONLY.)**

____

____

11. GIVE THE NAME OF THE LICENSED PENNSYLVANIA DENTIST, ASSOCIATED WITH THE HOSPITAL, WHO WILL BE RESPONSIBLE FOR SUPERVISING YOU DURING YOUR COURSE OF TRAINING. **(TO BE COMPLETED FOR POSTGRADUATE TRAINING ONLY.)**

_______________________	_______________________
Name of Dentist (Please Print)	Pennsylvania License Number
_______________________	_______________________
Signature of Supervising Dentist	Date

12. TO BECOME A FACULTY MEMBER, THIS FORM IS TO BE SIGNED BY THE DEAN OF THE DENTAL SCHOOL. **(TO BE COMPLETED FOR FACULTY MEMBERS ONLY.)**

_______________________	_______________________
Signature of Dean	Date

CERTIFICATION STATEMENT

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 certify 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 or revocation of my license, permit or certificate.

Signature of Applicant: ______________________________ Date: ______________

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CERTIFICATION OF GRADUATION

Part A – *To be completed by applicant..*

NAME ____
Last *First* *Middle*

ADDRESS ____
Street

____
City *State* *Zip Code*

Part B – *To be completed by proper official of the school.*

I CERTIFY THAT ____________________________ SUCCESSFULLY COMPLETED
Name of Applicant

THE REQUIRED COURSES IN THE STUDY OF DENTISTRY AND WAS GRADUATED FROM

____
Name of Dental School

____
City *State*

WITH A __________________ DEGREE ON ______________________.
DDS/DMD *Date Degree Conferred*

____
Signature of the Proper Official of School

(SEAL OF SCHOOL)

____
Date

FORM MUST BE SENT DIRECTLY TO THE BOARD IN AN OFFICIAL SCHOOL ENVELOPE.