

**KANSAS DENTAL BOARD**

900 SW Jackson, Ste 564, Topeka, KS 66612 785-296-6400 website www.kansas.gov/kdb

**REINSTATEMENT APPLICATION  
FOR A DENTIST ( ) OR HYGIENIST ( )**

**Dentists:** If you have not practiced for 5 years or more, you will be required to take a regional clinical exam before you can be reinstated.

**Hygienists:** If you have not practiced for 3 or more years, you must either complete a board approved refresher course, or pass a regional clinical exam before you can be reinstated.

1. (a) Name \_\_\_\_\_  
(Last) (First) (Middle) (Soc. Sec. No.)

You are required to provide your social security number as part of this application pursuant to 42 U.S.C. § 666(a)(13) and K.S.A. 74-148. Your social security will be used for identifying you, reporting to the National Practitioner Data Bank or Healthcare Integrity and Protection Data Bank and will be provided to the Kansas Department of Revenue pursuant to K.S.A. 74-139 and Kansas Social Rehabilitation Services pursuant to K.S.A. 74-148 and 39-758

(b) Have you used any other name? \_\_\_\_\_

(c) Current mailing address \_\_\_\_\_

(Street, City, County, State, Zip Code)

(d) Phone ( ) \_\_\_\_\_ Cell phone ( ) \_\_\_\_\_ Email Address: \_\_\_\_\_

2. Date of Birth \_\_\_\_\_ Place of Birth \_\_\_\_\_

3. What was your Kansas license number? \_\_\_\_\_ When were you licensed in Kansas? \_\_\_\_\_ When did you allow your license to be cancelled? \_\_\_\_\_

4. IF YOUR ANSWER IS "YES" TO ANY OF THE FOLLOWING QUESTIONS (a-d), YOU ARE REQUIRED TO ATTACH DOCUMENTATION AND A COMPLETE EXPLANATION:

- (a) \_\_\_ Yes \_\_\_ No Has any adverse judgment, award or settlement been paid in which you were named resulting from a professional liability claim?
- (b) \_\_\_ Yes \_\_\_ No Has any disciplinary action been taken or initiated against you by a state licensing agency or other state or federal agency, or have you surrendered or consented to limitation of license to practice in any state?
- (c) \_\_\_ Yes \_\_\_ No Have you been found guilty or pled no contest to any felony or class A misdemeanor?
- (d) \_\_\_ Yes \_\_\_ No Have you suffered from any impairment which would affect your ability to safely practice?
- (e) \_\_\_ Yes \_\_\_ No Do you have an investigation pending with any state licensing board?

5. Do you or have you ever been licensed to practice Dentistry/Dental Hygiene in other states? \_\_\_ No \_\_\_ Yes. If yes, list states and years licensed \_\_\_\_\_

6. Have you ever failed a Clinical or National Examination? Yes ( ) No ( ) If yes, provide details \_\_\_\_\_

**7. NOTICE TO APPLICANT**

I, \_\_\_\_\_, the applicant herein, deposes and says that all facts,  
(Print Name)

statements and answers contained in this application are true and correct; I am not omitting any information which might be of value to this Board in determining my qualifications and as an applicant shall be sufficient to bar me from this or any future examination given by the Kansas Dental Board and such falsifications, omissions, or withholding shall serve as sufficient grounds for the suspension, cancellation or revocation of my Kansas Dental/Hygiene License even though it is not discovered until after issuance.

I hereby give permission to the Kansas Dental Board to secure additional information concerning me or any statement in this application from any source the Board may desire. I further agree to submit to questioning by the Board or any member thereof, and to substantiate my statements if desired by the Board.

I do solemnly declare upon my honor that if granted a license to practice Dentistry/Dental Hygiene in Kansas I will respectfully comply with the law governing the practice of Dentistry/Dental Hygiene in this State and will do my best to uphold and maintain the ethics of the profession.

\_\_\_\_\_  
Signature

THIS SPACE FOR CURRENT PHOTOGRAPH OF APPLICANT

Subscribed and sworn to before me this \_\_\_\_\_  
day of \_\_\_\_\_ 20\_\_\_\_\_

Notary Public \_\_\_\_\_

My Commission Expires: \_\_\_\_\_

**INSTRUCTIONS TO APPLICANTS**

**Include the following with your application:**

1. \_\_\_\_\_ Provide evidence (certificates or other proof) of the following schedule of continuing education hours:

	<b>Dentists:</b>	<b>Hygienists</b>
Up to 5 years	100 hours	50 hours
4 years	80 hours	40 hours
3 years	70 hours	35 hours
2 years	60 hours	30 hours
1 year	30 hours	15 hours

2. \_\_\_\_\_ Official verification from all state boards in which you hold or have held a license

3. \_\_\_\_\_ National Practitioner Data Bank and Health Integrity and Protections Databank Self-Queries (see instructions below)

4. \_\_\_\_\_ **FEE:** To reinstate a cancelled license, include a check or money order for **\$200**.  
If you are applying to reinstate a revoked license, you must wait 3 years, fee is \$2000.

Provide all of the above and send with the completed application to:

Kansas Dental Board  
900 SW Jackson, Suite 564  
Topeka, KS 66612

5. \_\_\_\_\_ Once we receive the application you may make arrangements to take the jurisprudence (JP) exam in our office or at a dental school or hygiene school. Email [info@dental.state.ks.us](mailto:info@dental.state.ks.us) or call the office to make arrangements. You will be notified of your JP results and your **prorated fee** in writing. Do not call for results. You will receive an invoice for the prorated fee. Once paid, your license will be mailed to you; the wall certificate will be mailed after the next board meeting.

### **SELF QUERY INSTRUCTIONS: National Practitioner Data Bank and Healthcare Integrity and Protection Databank Reports**

All candidates for dental or dental hygiene licensure are required to self-query the National Practitioner Data Bank/Healthcare Integrity and Protection Data Bank. The self-query must be completed on the internet. Instructions for accessing the self-query forms are as follows:

- . Go to: [www.npdb-hipdb.com](http://www.npdb-hipdb.com)
- . At the top of this page, click on: Quick List / Perform Self-Query
- . Click on: Go to the Self-Query Service
- . Choose Individual Self-Query
- . Print and follow instructions for self-query
- . Complete form on-line following your printed instructions.

You will need a credit card for payment of the querying fees of \$16.00 (\$8.00 for each report). Upon completion of the self-query form, follow instructions for printing and notarizing the form. Federal law requires that the self-query results be mailed directly to you with an approximate turn-around time of 3-4 weeks. If you should have questions pertaining to your self-query you may call: **Data Bank Customer Service at 800-767-6732**

Provide a self-query of the National Practitioner Data Bank and the Health Integrity and Protection Databank. This is a one page report.