



Jeremiah W. (Jay) Nixon  
Governor  
State of Missouri

Kathleen (Katie) Steele Danner, Division Director  
DIVISION OF PROFESSIONAL REGISTRATION

Department of Insurance  
Financial Institutions  
and Professional Registration  
John M. Huff, Director

MISSOURI DENTAL BOARD  
3605 Missouri Boulevard  
P.O. Box 1367  
Jefferson City, MO 65102-1367  
573-751-0040  
573-751-8216 FAX  
800-735-2966 TTY  
800-735 2466 Voice Relay Missouri  
[dental@pr.mo.gov](mailto:dental@pr.mo.gov)  
<http://www.pr.mo.gov>

Brian Barnett  
Executive Director

Dear Specialty Applicant,

Please find the attached application for licensure as a dental specialist in the State of Missouri. In order to obtain a specialty license, you must first obtain a general dentistry license in Missouri. If you need an application packet for a general dentistry license, please refer to <http://www.pr.mo.gov> or contact the Board office at the address/phone number above and one can be mailed to you.

You may be issued a Missouri specialty license by one of the following methods:

- Being a current diplomate of an examining board recognized by the American Dental Association; or
- Having completed a dental specialty program accredited by the Council on Dental Accreditation.

If you have any questions regarding specialty licensure in Missouri, please do not hesitate to contact the board office at (573) 751-0040.



**STATE OF MISSOURI**  
 DIVISION OF PROFESSIONAL REGISTRATION  
**APPLICATION FOR LICENSURE – DENTAL SPECIALIST**

MISSOURI DENTAL BOARD  
 3605 MISSOURI BOULEVARD  
 PO BOX 1367  
 JEFFERSON CITY MO 65102-1367  
 TELEPHONE: (573) 751-0040  
 FAX: (573) 751-8216  
 TTY: (800) 735-2966

**INSTRUCTIONS**

- This form must be typed or printed legibly in **black** ink.
- Provide complete information (incomplete information will delay the processing of your application).
- Enclose the **\$330.00** application and licensure fees in the form of a check or money order made payable to the Missouri Dental Board (all fees are non-refundable).
- Attach a recent photograph of yourself in the space provided to the right of this section.
- An official final transcript of your specialty training program must be sent directly to the Board, if applicable.
- Complete and forward the Verification of Specialty Training form to the Director of your specialty training program. This form must be returned directly to the Board from your Program Director.
- If you hold or have ever held a specialty license in another state, complete Section I of the enclosed Verification of Specialty Licensure form and forward the form to the appropriate state dental licensing board. This form must be received by the Missouri Dental Board directly from the state verifying your specialty credentials.

AFFIX  
 PHOTOGRAPH  
 TAKEN WITHIN  
 THE LAST  
 SIX MONTHS

**This application is being submitted on the basis that I:**

- 1. Am a Current Diplomate of an Examining Board recognized by the American Dental Association; or
- 2. Have completed a dental specialty program accredited by the Council on Dental Accreditation; or
- 3. Have a current specialty license in another state and I meet the requirements of either option 1 or 2 above.

**SECTION I - APPLICANT DATA**

NAME (FIRST, MIDDLE, LAST, SUFFIX, FORMER/MAIDEN)			DATE OF BIRTH	
HOME TELEPHONE NUMBER	BUSINESS TELEPHONE NUMBER	FAX	PLACE OF BIRTH	
HOME STREET ADDRESS (IF PO BOX, PLEASE ALSO PROVIDE A STREET ADDRESS)		CITY	STATE	ZIP CODE
BUSINESS ADDRESS		CITY	STATE	ZIP CODE
USE AS MY MAILING ADDRESS (CHECK ONLY ONE BOX) <input type="checkbox"/> Home or <input type="checkbox"/> Business		E-MAIL ADDRESS		SOCIAL SECURITY NUMBER*

**SECTION II - LICENSURE INFORMATION**

MISSOURI DENTAL LICENSE NUMBER	DATE OF ISSUANCE
SPECIALTY AREA FOR WHICH YOU ARE APPLYING	
<input type="checkbox"/> Endodontics	<input type="checkbox"/> Oral and Maxillofacial Radiology
<input type="checkbox"/> Pediatric Dentistry	<input type="checkbox"/> Periodontics
<input type="checkbox"/> Orthodontics and Dentofacial Orthopedics	<input type="checkbox"/> Oral and Maxillofacial Surgery
	<input type="checkbox"/> Prosthodontics
	<input type="checkbox"/> Oral Pathology
	<input type="checkbox"/> Public Health
ARE YOU A DIPLOMATE OF EXAMINING BOARD RECOGNIZED BY THE AMERICAN DENTAL ASSOCIATION?	
<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, which board:	
ARE YOU LICENSED AS A SPECIALIST IN ANY OTHER STATE(S)?	
<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, which state(s):	
HAVE YOU TAKEN A SPECIALTY EXAM IN ANY OTHER STATE(S)?	
<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, which state(s):	

**SECTION III - POST-GRADUATE TRAINING**

NAME OF SPECIALTY PROGRAM ATTENDED (SCHOOL, HOSPITAL, OTHER SETTING)	CITY/STATE	FROM		TO		DATE COMPLETED
		MO.	YR.	MO.	YR.	

Pursuant to Section 324.010 RSMo:

**CHECK THIS BOX ONLY IF IN ALL OF THE LAST 3 YEARS: YOU WERE NOT A MISSOURI RESIDENT, YOU DID NOT HAVE ANY MISSOURI INCOME, AND YOU ARE NOT SUBJECT TO ANY TYPE OF MISSOURI INCOME TAX.**

***False statements are subject to criminal penalties and/or license discipline.***

**If you have any questions regarding taxes contact the Department of Revenue at 573-751-7200 or e-mail [income@dor.mo.gov](mailto:income@dor.mo.gov).**

**SECTION IV - SWORN AFFIDAVIT**

I, the below named applicant, being duly sworn, hereby affirm under penalties of perjury that I am the applicant referred to in the preceding application for a license to practice as a dental specialist in the state of Missouri, and that all statements and enclosures are true and accurate to the best of my knowledge, information and belief.

I submit in consideration this application as required by the Missouri law governing the practice of dentistry and subject to the rules and regulations of the Missouri Dental Board. I subscribe and agree to abide by all applicable laws and rules regarding the practice of dentistry. I hereby certify that I have familiarized myself with Chapter 332 RSMo, known as the Dental Practice Act and applicable rules promulgated by the Missouri Dental Board.

I understand the Board may require further information or evidence that it deems reasonable and proper. Furthermore, I voluntarily consent to a thorough investigation of my present and past employment and other activities for the purpose of verifying my qualifications.

<b>MUST BE SIGNED IN PRESENCE OF NOTARY ▶</b>	SIGNATURE OF APPLICANT	
	STATE	COUNTY (OR CITY OF ST. LOUIS)
NOTARY PUBLIC EMBOSSEER OR BLACK INK RUBBER STAMP SEAL	SUBSCRIBED AND SWORN BEFORE ME, THIS	
	DAY OF	YEAR
	<b>USE RUBBER STAMP IN CLEAR AREA BELOW.</b>	
	NOTARY PUBLIC SIGNATURE	MY COMMISSION EXPIRES
NOTARY PUBLIC NAME (TYPED OR PRINTED)		

**SOCIAL SECURITY NUMBER DISCLOSURE NOTICE**

**You must provide your social security number pursuant to state and federal law. <sup>1</sup>**

**If you fail or refuse to provide your social security number, we will consider your initial application or renewal application incomplete and return it to you. Continued failure or refusal to provide your social security number is grounds for denial of your application and could result in the imposition of late fees, administrative revocation of your license, a lapsed license or disciplinary action against your license.**

Pursuant to state and federal law, licensing authorities must assemble your social security number with other relevant information (name, address, etc.) and transmit the data to the Division of Child Support Enforcement of the Department of Social Services to be used in a database for the following purposes:

- (1) locating individuals who are under an obligation to pay child support or provide child custody or visitation rights, against whom such an obligation is sought or to whom such an obligation is owed;
- (2) identifying whether an individual who owes overdue child support or who has failed to comply with a subpoena relating to paternity or child support proceedings holds or has applied for a professional or occupational license (under certain circumstances, a person who owes overdue child support or fails to comply with a subpoena relating to the above-stated proceedings may be subject to an order of a court, after notice and opportunity for hearing in that court, suspending, withholding or restricting the person's license).

In addition to these uses, the licensing authorities will continue their practice of using social security numbers for the following purposes:

- (1) for internal identification purposes (e.g., some licensing authorities use your social security number as your license number);
- (2) to conduct criminal record checks (discovery of relevant criminal history may result in denial of your application, conditioned licensure or the filing of a disciplinary action against you);
- (3) to verify information provided by you in your application (discovery of false information in your application may result in denial of your application, conditioned licensure or the filing of a disciplinary action against you);
- (4) to verify licensure with another state's licensing authority for reciprocity licensure;
- (5) for identification purposes in national disciplinary databases (the discovery of a disciplined license in another state may result in denial of your application, conditioned licensure or the filing of a disciplinary action against you);
- (6) for test identification purposes.

<sup>1</sup>Senate Bill 361, 89th General Assembly, First General Session (1997); Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. No. 104-193.



**STATE OF MISSOURI**  
 DIVISION OF PROFESSIONAL REGISTRATION  
**VERIFICATION OF SPECIALTY TRAINING**

MISSOURI DENTAL BOARD  
 3605 MISSOURI BOULEVARD  
 PO BOX 1367  
 JEFFERSON CITY, MO 65102-1367  
 TELEPHONE: (573) 751-0040  
 FAX: (573) 751-8216  
 TTY: (800) 735-2966

**SECTION I - TO BE COMPLETED BY APPLICANT**

**Instructions**  
 Complete Section I and mail this form to your Specialty Training Program Director for verification that you graduated from an accredited specialty training program.

NAME (FIRST, MIDDLE, LAST, SUFFIX)

MAILING ADDRESS (STREET, CITY, STATE, ZIP)

The Missouri Dental Board requires that I submit evidence of my having met the requirements to obtain a specialty license. You are hereby authorized to release any information in your possession pertaining to me, favorable or otherwise, directly to the Missouri Dental Board at the above address.

APPLICANT SIGNATURE DATE

**SECTION II - TO BE COMPLETED BY SPECIALTY TRAINING PROGRAM DIRECTOR**

**Instructions**  
 Please indicate below if the above-named applicant has graduated from a specialty training program accredited by the Council on Dental Accreditation and return this form directly to the Missouri Dental Board. Thank you.

NAME OF SPECIALTY TRAINING PROGRAM DIRECTOR (PLEASE PRINT) TELEPHONE

NAME AND LOCATION OF SPECIALTY TRAINING PROGRAM

DID THE APPLICANT GRADUATE FROM A SPECIALTY TRAINING PROGRAM ACCREDITED BY THE COUNCIL ON DENTAL ACCREDITATION?  
 Yes  No If the answer is "No", please attach a detailed explanation as to the applicant's education and training.

DATES APPLICANT ATTENDED THE PROGRAM ▶	FROM		TO		DATE PROGRAM COMPLETED
	MO.	YR.	MO.	YR.	

SPECIALTY AREA COMPLETED

- Endodontics
- Oral and Maxillofacial Radiology
- Oral and Maxillofacial Surgery
- Oral Pathology
- Orthodontics and Dentofacial Orthopedics
- Pediatric Dentistry
- Periodontics
- Prosthodontics
- Public Health

SEAL OF SCHOOL, HOSPITAL OR OTHER SETTING

SIGNATURE - SPECIALTY TRAINING PROGRAM DIRECTOR

DATE