



DEPARTMENT OF COMMERCE, COMMUNITY, AND ECONOMIC DEVELOPMENT  
DIVISION OF CORPORATIONS, BUSINESS AND PROFESSIONAL LICENSING  
BOARD OF DENTAL EXAMINERS  
333 Willoughby Avenue, 9th Floor  
P.O. Box 110806  
Juneau, Alaska 99811-0806  
(907) 465-2542  
E-mail: [license@alaska.gov](mailto:license@alaska.gov)  
Website: [www.commerce.state.ak.us/occ/pden.htm](http://www.commerce.state.ak.us/occ/pden.htm)

## ALASKA DENTAL LICENSE BY EXAMINATION

### LEVEL III PROFESSIONAL BACKGROUND INFORMATION SERVICE REPORT (PBIS)

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No person, except those specifically exempted from the Alaska Statute pertaining to the practice of dentistry in Alaska, may practice dentistry without a current and active license.

The Alaska Board of Dental Examiners accepts the results from the Western Regional Examining Board (WREB) in lieu of giving their own examination. AS 08.36.160(e) requires that an applicant obtain a passing score within the five years preceding licensure application. For information regarding the WREB examination please write to:

**Western Regional Examining Board**  
9201 North 25<sup>th</sup> Avenue, Suite 185  
Phoenix, AZ 85021  
Telephone: (602) 944-3315  
Fax: (602) 371-8131  
Website: [www.wreb.org](http://www.wreb.org)  
E-mail Address: [generalinfo@wreb.org](mailto:generalinfo@wreb.org)

#### LEVEL III PROFESSIONAL BACKGROUND INFORMATION SERVICE CREDENTIAL REVIEW (PBIS)

The results of Level III Professional Background Information Services (PBIS) credentials review conducted by PBIS must be sent directly to the department from PBIS. This process generally takes between one and three months. Please plan accordingly. Contact PBIS directly at the below address:

**Professional Background Information Services**  
23460 N. 19<sup>th</sup> Avenue, Suite 225  
Phoenix, AZ 85027  
Telephone: (602) 861-5867  
Fax: (602) 861-9656  
Website: [www.pbisonline.com](http://www.pbisonline.com)  
E-mail: [pbisaz@aol.com](mailto:pbisaz@aol.com)

#### DOCUMENTS TO BE SUBMITTED IN PBIS LEVEL III REPORT

This report is required of those applicants who have not previously held a dentist license in any jurisdiction before the 90 days immediately preceding the date of application. You will need to arrange with PBIS for submission of a Level III credentials report to be sent directly to the department by PBIS.

#### DOCUMENTS TO BE SUBMITTED BY APPLICANT:

1. Complete, signed and notarized application form 08-4165;
2. Nonrefundable application fee of \$300.00;
3. License fee of \$290.00;
4. Statement of Ethical Standards form 08-4165d;

5. Authorization for Release of Records form 08-4165b;
6. Impaired Practitioner Affidavit form 08-4165c;
7. Official transcripts sent directly from dental school;
8. Drug Enforcement Administration (DEA) verification form 08-4165a. This must be submitted from DEA for verification even if you are not currently registered with DEA;
9. Copy of current certification cardiopulmonary resuscitation (CPR) card;
10. Copy of examination certificate from WREB indicating that you have successfully passed the examination;
11. Copy of National Board examination scores indicating successful passage of exam; and
12. Verification of All Dental Association Membership form 08-4165e.

#### **OTHER INFORMATION REQUIRED FOR LICENSURE**

1. As required by AS 08.36.110(F), the Division will query the National Practitioner Data Bank (NPDB) and the American Association of Dental Examiners Clearinghouse for Disciplinary Information that relates to criminal or fraudulent activity, negligent dental care, or malpractice.
2. Upon receipt of an application, the Jurisprudence Examination will be mailed to applicants for completion.  
  
All Applicants must complete the board's Jurisprudence examination. The examination is open book consisting of 25 multiple choice question. Once an application is on file, the examination will be mailed to the applicant for completion.
3. For your information, there are separate applications for Specialty License, General Anesthetic Permit, Parenteral Sedation Permit and Branch Office. If you need to apply for any of licenses or permits you may download the applications from the website: [www.commerce.state.ak.us/occ](http://www.commerce.state.ak.us/occ) or contact this office to request that the application(s) are mailed to you.
4. Wall certificate fee of \$20.00 (optional).

#### **GENERAL INFORMATION**

When submitting fees, make check or money order payable to the State of Alaska.

#### **APPLICATION REVIEW**

Applications will be processed according to the date received. You will be notified in writing as soon as your application has been reviewed.

Applications are processed as quickly as possible. Unnecessary telephone calls to our office delay processing. Because of telephone calls regarding the status of application and because of privacy issues, **we prefer to restrict our telephone responses to the applicant only**. If you are concerned about your application being received in our office, mail it "Certified – Return Receipt Requested." You will receive a delivery notice from the post office.

The Board of Dental Examiners meets four times a year, usually in March, June, September, and December. The meeting dates are available on the board website at: [www.commerce.state.ak.us/occ/pden.htm](http://www.commerce.state.ak.us/occ/pden.htm). Applications received and complete (including **all** supporting documentation) within two or three weeks of a board meeting will be reviewed at the board meeting; otherwise, completed applications will be sent to the board members using the mail ballot voting process.

#### **"YES" RESPONSES**

A "Yes" response in the application does not mean your application will be denied. If you have responded "Yes" to any question in the application, additional time will be required for the gathering and assessment of pertinent information.

## **HOW CAN YOU HELP?**

1. First and foremost: Apply far enough in advance to allow for application processing.
2. If you are concerned about your application being received in our office, mail it Certified-Return Receipt.
3. If you wish to expedite processing as much as you can, send any necessary verification forms out via overnight mail to the appropriate organization and include a return overnight mail envelope addressed to the licensing examiner for the organization's use. This will help them to respond quickly.
4. Insure that the application is complete and provide any necessary explanations with the application. Print legibly or type your application.
2. Provide complete explanations for any "YES" responses; it saves time if we don't have to request such information.
3. Provide a brief description for any malpractice claims describing what allegations was the nature of the case, your level of involvement, and the resolution of the case.

## **RENEWAL INFORMATION**

All Dentist licenses expire on December 31, of even numbered years regardless of when issued, except new licenses issued within 90 days of the expiration date which are issued through the next biennium.

## **ADDRESS CHANGE**

In accordance with 12 AAC 02.900 a person must notify the division in writing, of a change of address.

## **SOCIAL SECURITY NUMBERS**

Alaska Statute 08.01.060(b) requires an applicant for an occupational license to provide a United States Social Security Number. Applicants who do not have a social security number must complete the "Request for Exception from Social Security Number Requirement" form located on the division's website at: [www.commerce.state.ak.us/occ](http://www.commerce.state.ak.us/occ) or contact the division to request the form.

## **PUBLIC INFORMATION**

Please be aware that all information on the initial application form will be available to the public, unless required to be kept confidential by state or federal law. Information about current licensees, including mailing addresses, is available on the division's website at [www.commerce.state.ak.us/occ](http://www.commerce.state.ak.us/occ), under "License Search."

## **PAYMENT OF CHILD SUPPORT AND STUDENT LOANS**

If the Alaska Child Support Enforcement Division has determined that you are in arrears on child support, or if the Alaska Commission on Post-Secondary Education has determined you are in loan default, you may be issued a nonrenewable temporary license valid for 150 days. Contact Child Support Services at (907) 269-6900 or the Post-Secondary Education office at (907) 465-2962 or 1-800-441-2962 to resolve payment issues.

## **BOARD NEWSLETTER**

The Board of Dental Examiners newsletter is available for viewing on the board website at: [www.commerce.state.ak.us/occ/pden.htm](http://www.commerce.state.ak.us/occ/pden.htm).

## **STATUTES AND REGULATIONS**

The complete set of Board of Dental Examiners statutes and regulations is available on the board's website or contact the division and request a copy by mail.

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FOR OFFICE USE ONLY

APPLICATION FOR DENTAL LICENSE BY EXAMINATION  
LEVEL III PBIS CREDENTIAL REVIEW REPORT

NONREFUNDABLE APPLICATION FEE: \$300.00   
LICENSE FEE: \$290.00   
WALL CERTIFICATE FEE (OPTIONAL): \$ 20.00

I HEREBY APPLY for a license to practice dentistry in the State of Alaska, and submit the following statements, under oath, and herewith enclose the required documents and fees.

**INSTRUCTIONS TO THE APPLICANT:** It is the responsibility of the applicant to ensure that all information requested in this application is received. Each question must be answered fully, truthfully, and accurately. Any omissions or inaccuracies are grounds for disapproval and rejection. Section 08.36.315(1) of the Dental Practice Act provides that knowingly cooperating in deceit, fraud, or intentional misrepresentation to obtain a license is cause for suspension, revocation, or annulment of licensure. If the space of any answer is insufficient, the applicant may complete his/her answer on an additional sheet signed by him/her and specifying the number of the question to which it relates.

**Type or print all requested data.**

1. **Name in full** \_\_\_\_\_ SSN: \_\_\_\_\_  

Last
First
Initial

(Required by AS 08.01.060(b))
2. Other names used, including maiden name: \_\_\_\_\_
3. Mailing Address: \_\_\_\_\_  

City
State
Zip Code:
4. Business Address: \_\_\_\_\_  

City
State
Zip Code:
5. Daytime Telephone Number: \_\_\_\_\_ Home Telephone Number: \_\_\_\_\_
6. Sex:  Female  Male Date of Birth: \_\_\_\_\_

**PRE-DENTAL EDUCATION**

7. High School: \_\_\_\_\_  
City and State: \_\_\_\_\_ Year of Graduation: \_\_\_\_\_
8. College or University: \_\_\_\_\_  
City and State: \_\_\_\_\_  
Year of Attendance: \_\_\_\_\_ Semester Hours: \_\_\_\_\_ Degree: \_\_\_\_\_

**DENTAL EDUCATION**

9. School of Dentistry: \_\_\_\_\_  
 City and State: \_\_\_\_\_  
 Degree (DDS or DMD): \_\_\_\_\_ Exact Date of Diploma: \_\_\_\_\_

10. EXAMINATION INFORMATION

A. A candidate must have passed both parts of the National Board Examinations.

Part I passed \_\_\_\_\_ Date \_\_\_\_\_ Part II passed \_\_\_\_\_ Date \_\_\_\_\_

B. A candidate must have passed the WREB Examination within 60 months prior to application:

Date passed: \_\_\_\_\_

11. Have you ever served in the uniformed services? \_\_\_\_\_ If so, branch of service \_\_\_\_\_  
 date of commission \_\_\_\_\_, date of discharge \_\_\_\_\_, rank \_\_\_\_\_  
 serial number \_\_\_\_\_. If separated from the services, state nature of separation and if other than honorable, specify type and circumstances surrounding your release. Give full particulars as to any conviction by court martial while serving in the uniformed services. \_\_\_\_\_

12. List all states or jurisdictions in which you are currently or ever have been licensed. List state, license number, date of issuance, and years of practice in each state. If none, please indicate.

State/ Jurisdiction	License No.	Date of Issuance (Month/Day/Year)	Dates Practiced	
			From (Month/Day/Year)	To (Month/Day/Year)

13. Give address of all locations with dates showing length of time spent in each location in which you have practiced. If none, please indicate.

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

During this period, did you always maintain your own office? \_\_\_\_\_ If not, list names and addresses of dentists by whom you were employed. \_\_\_\_\_

14. Give the name and location of each dental association which you are now, or have been a member (including student membership) and send attached Verification of Dental Association Membership forms to respective association(s). If none, please indicate.

\_\_\_\_\_

15. If you answer "YES" to any questions, please explain in full, on a separate affidavit, and enclose applicable legal documentation.

	YES	NO
a. Have you ever practiced dentistry illegally? .....	<input type="checkbox"/>	<input type="checkbox"/>
b. Have you had a license to practice dentistry revoked, suspended, or voluntarily surrendered in this state or another state? .....	<input type="checkbox"/>	<input type="checkbox"/>
c. Have you ever been reprimanded, censured, or otherwise disciplined or disqualified as a dentist or other professional? .....	<input type="checkbox"/>	<input type="checkbox"/>
d. Have you ever been convicted of a felony or other crime? .....	<input type="checkbox"/>	<input type="checkbox"/>
e. Do you have any criminal charges pending against you? .....	<input type="checkbox"/>	<input type="checkbox"/>
f. Have there been any judgments or unsatisfied judgments against you resulting from the practice of dentistry? .....	<input type="checkbox"/>	<input type="checkbox"/>
g. Are you the subject of an adverse decision based upon a complaint, investigation, review procedure, or other disciplinary proceeding within the five years immediately preceding application, or of an unresolved complaint, investigation, review procedure, or other disciplinary proceeding, undertaken by a state, territorial, local, or federal dental licensing jurisdiction or a dental society? .....	<input type="checkbox"/>	<input type="checkbox"/>
h. Are you the subject of an unresolved or an adverse decision based upon a complaint, investigation, review procedure, or other disciplinary proceeding, undertaken by a state, territorial, local, or federal dental licensing jurisdiction, dental society, or law enforcement agency that relates to criminal or fraudulent activity, dental malpractice, or negligent dental care and that adversely reflects on your ability or competence to practice dentistry or on the safety or well-being of patients? .....	<input type="checkbox"/>	<input type="checkbox"/>
i. Within the five years immediately preceding your completion and submission of this application for licensure, have you suffered from, or been treated for emotional or mental illness or substance abuse (including, but not limited to, alcohol, narcotics, or any other substance)? .....	<input type="checkbox"/>	<input type="checkbox"/>

Please be aware that all information on this form and supplied with this form will be available to the public, unless required to be kept confidential by state or federal law.

16. I HEREBY CERTIFY that the information contained in this application is true and correct to the best of my knowledge. I understand that any false information or falsification of credentials may result in failure to obtain a license to practice dentistry in Alaska.

I have read the Alaska Dental Practice Act. I solemnly declare upon my honor that, if granted a license to practice dentistry in Alaska, I will respectfully comply with any law governing the practice of dentistry in this state, and I will do my best to uphold and maintain the ethics of the profession.

SIGN HERE  \_\_\_\_\_  
Signature of Applicant

SUBSCRIBED AND SWORN before me, a Notary Public, in and for the State of \_\_\_\_\_  
this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

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

NOTARY SEAL

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

**TO THE APPLICANT:**

This form must be submitted to the DEA office at the address below. Complete the identifying information even if you do not hold DEA authority and submit to:

**Drug Enforcement Administration  
Attention: Registration  
400 2nd Avenue, West  
Seattle, Washington 98119**

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P.O. BOX 110806  
JUNEAU, ALASKA 99811-0806**

Date: \_\_\_\_\_

**TO WHOM IT MAY CONCERN:**

I am applying for a license to practice dentistry in the State of Alaska. Please indicate on the lower portion of this letter if there is any derogatory information on file against me and send this information directly to the Alaska Board of Dental Examiners. Thank you for your assistance.

**NAME:** \_\_\_\_\_

**DATE OF BIRTH:** \_\_\_\_\_

**DEA REGISTRATION NUMBER:** \_\_\_\_\_

**ADDRESS WHERE DEA NUMBER IS REGISTERED:** \_\_\_\_\_

\_\_\_\_\_  
Signature of Applicant

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**DEA RESPONSE:**

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**AUTHORIZATION FOR RELEASE OF RECORDS**

**TO WHOM IT MAY CONCERN:**

I, \_\_\_\_\_, residing at \_\_\_\_\_

\_\_\_\_\_, authorize the Alaska Division of Corporations, Business and Professional Licensing and its investigators to examine my medical, dental, employment, educational records, and records pertaining to litigation, judgments, suits and/or settlements, and any law enforcement records pertaining to me and discuss them with persons having possession of them. I also expressly permit and authorize the release of all such records pertaining to me to the Alaska Division of Corporations, Business and Professional Licensing and its investigators.

This release also applies to any documents or records which contain information pertaining to psychiatric, drug or alcohol evaluation, diagnosis or treatment received by me and which were prepared or made in conjunction with, or under the authority or guidance of any local, state, or federal law which relates to psychiatric, drug or alcohol evaluation, diagnosis or treatments.

This release specifically includes information from federal service and peer review organizations.

I request that upon presentation of this release, or a true copy, that you provide copies of those records to the division and its investigators.

I authorize the division to discuss my records with persons or organizations which are considered appropriate by the division in connection with an official investigation, and to provide copies of my records to those persons or organizations if appropriate.

This authorization is given expressly in connection with my application (initial, renewal, reactivation) for Alaska Dental Licensure. This authorization expires one year from the date of my signature.

My Date of Birth is: \_\_\_\_\_

I hereby release you, your organization, the Alaska Department of Commerce, Community, and Economic Development, Division of Corporations, Business and Professional Licensing, and its investigators, and all others directly or indirectly involved in this matter from any liability or damage which may result from furnishing the information requested.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Home Telephone: (     ) \_\_\_\_\_ Work Telephone: (     ) \_\_\_\_\_

**NOTE: A photocopy reproduction of this request shall be, for all intents and purposes, as valid as the original.**

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**IMPAIRED PRACTITIONER AFFIDAVIT**

**TO WHOM IT MAY CONCERN:**

I, \_\_\_\_\_, residing at \_\_\_\_\_  
\_\_\_\_\_

swear to the Board of Dental Examiners, through this affidavit, that I am not an impaired practitioner.

I understand that any false or misleading information may result in denial, suspension, or revocation of the license for which I have applied, or for any Alaska dental license that I now hold.

Per AS 08.36.370(3), "impaired practitioner" means a person who is unfit to practice dentistry due to addiction or dependence on alcohol or other drugs that impair the practitioner's ability to practice safely.

Applicant/Licensee Signature: \_\_\_\_\_

SUBSCRIBED AND SWORN to before me, a Notary Public in and for the State of \_\_\_\_\_,  
this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

SEAL

\_\_\_\_\_  
Signature of Notary Public

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

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## STATEMENT OF ETHICAL STANDARDS

I acknowledge and understand that a licensed dentist in Alaska shall adhere to the ethical standards for dentists established by the Alaska Board of Dental Examiners and that failure to adhere to the ethical standards may result in imposition of a sanction that is described in AS 08.36.315.

By signature below, I certify that if I am granted licensure in the State of Alaska as a dentist, I will adhere to The American Dental Association's Principles of Ethics and Code of Professional Conduct, with official advisory opinions revised to April 2002, is adopted by reference as the ethical standards for dentists and applies to all dentists in the state (12 AAC 28.905(b)).

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Printed Name

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Signature of Applicant

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Date

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**VERIFICATION OF DENTAL ASSOCIATION MEMBERSHIP**

To Whom It May Concern:

I am applying for a license to practice Dentistry in the State of Alaska. The Board of Dental Examiners requires that this form be completed by each dental association which I am or ever have been a member. Please complete the form and return it directly to the Board of Dental Examiners at the above address.

Name \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

Date of Birth \_\_\_\_\_

**PLEASE DO NOT DETACH. The information below must be completed by the Dental Association, and not by the applicant.**

Name of Dental Association \_\_\_\_\_

State of \_\_\_\_\_

Name of Applicant \_\_\_\_\_

Member No. \_\_\_\_\_ issued effective \_\_\_\_\_

Membership is current \_\_\_\_\_ lapsed \_\_\_\_\_ Expiration date \_\_\_\_\_

Has the applicant ever been the subject of an adverse decision based upon a complaint, investigation, review procedure, or other disciplinary proceeding within the five years immediately preceding application, or of an unresolved complaint, investigation, review procedure, or other disciplinary proceeding undertaken by your dental society?  Yes  No

If so, for what reason? \_\_\_\_\_

Has the applicant ever been the subject of an unresolved or an adverse decision based upon a complaint, investigation, review procedure, or other disciplinary proceeding undertaken by your dental society that relates to criminal or fraudulent activity, dental malpractice, or negligent dental care and that adversely reflects on the applicant's ability or competence to practice dentistry or on the safety or well-being of patients?  Yes  No

If so, for what reason? \_\_\_\_\_

Signed \_\_\_\_\_

Title \_\_\_\_\_

Dental Association \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

Telephone Number \_\_\_\_\_

Date \_\_\_\_\_