STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS

BUSINESS, CONSUMER SERVICES, AND HOUSING AGENCY • GAVIN NEWSOM, GOVERNOR
DENTAL BOARD OF CALIFORNIA
2005 Evergreen St., Suite 1550, Sacramento, CA 95815
P (916) 263-2300 | F (916) 263-2140 | www.dbc.ca.gov

CALIFORNIA DENTAL CORPS
LOAN REPAYMENT PROGRAM APPLICATION

Business and Professions Code 1972

Please print or type legibly.

Section 1: Personal Data

Last Name:	First Name:		M.I.:
Previous Names (Including Maiden):	Date of Birth:	SSN/FEIN/ITIN #:	
Residence Address:	City:	State:	Zip Code:
Mailing Address:	City:	State:	Zip Code:
Home Phone:	Alternate Phone:	Email:	

Section 2: Selection Criteria

You may be asked to provide documentation to substantiate your answers to any of the following questions.

1. Do you hold a current valid license to practice dentistry in California?	◯ Yes	◯ No

License Number:	Date of Initial Issuance:	Expiration Date:

If NO, are you currently eligible for graduation from a pre-doctoral or post-doctoral dental education program approved by the Board or the Commission on Dental Accreditation?

◉ Yes, I am expected to graduate from _____
(Name of University)

with the degree of _____ on the _____ day of _____, 20_____.

◯ No

2. Do you speak a Medi-Cal threshold language?	◯ Yes	◯ No
Language(s):		
3. Do you come from an economically disadvantaged background?	◯ Yes	◯ No

4. Do you have prior experience working in a health field in an underserved area, or with an underserved population?	◯ Yes	◯ No
Facility name:		
Street address:		
Health field:	Dates worked:	
5. Have you completed a specialty residency program approved by the Commission on Dental Accreditation?	◯ Yes	◯ No
Facility name:		
Street address:		
Specialty:	Dates attended:	
6. Are you a specialist of a Board recognized by the American Dental Association?	◯ Yes	◯ No
Name of Specialty Board:	Date first certified:	
7. Have you completed an extra-mural program or rotation during dental school or postgraduate training in which you provided services to a population that speaks any Medi-Cal threshold language?	◯ Yes	◯ No
Facility name:		
Street address:		
Language(s) spoken by population:		
Specialty:	Dates attended:	
8. Are you willing to participate in the program if you are granted either less than you have requested in repayment, or less than the maximum repayment allowed under this program?	◯ Yes	◯ No
9. Will you be providing dental services at multiple practice settings?	◯ Yes	◯ No
10. Will you be providing services at a non-profit corporation or a community clinic?	◯ Yes	◯ No
11. Please describe your background and experience as it relates to your interest in this program.		

Section 3: Educational Debt

1. Please list your outstanding government or commercial educational loans. If you have additional outstanding educational loans, list them on a separate page. *NOTE: Applicants must submit a current loan statement for each educational loan identified. Each statement must clearly indicate the following: a) the loan company's name, b) the loan company's mailing address, c) your name, d) the loan account number, e) the outstanding balance, and f) the issue date of the loan statement.*

Loan Company Name:

Loan Company Name:

Loan Company Name:

Loan Company Name:

2. Are you currently participating in any other educational loan repayment or loan reduction program?	◯ Yes	◯ No
Program(s):		
3. Have you ever been, or are you currently, in default or have judgment liens against you for any debt, including but not limited to, taxes or educational assistance programs? *If YES, please attach a full explanation.*	◯ Yes	◯ No

Section 4: Provision of Services

1. Are you willing to sign a written contract with the Dental Board of California, whereby you commit to a minimum of 36 months of full-time service in a dentally underserved area?	◯ Yes	◯ No
2. Are you willing to provide an annual progress report verifying your employment with the practice site?	◯ Yes	◯ No

3. Please list the practice site at which you are working or have entered into a written agreement to provide services under this program during the next three years. If you are proposing a work arrangement with multiple practice settings, please list these clinics on a separate sheet and identify the percentage of hours to be provided at each site.

Practice setting:

Street address:	City:	State:	Zip Code:

Note to applicant: *The administrative official of the practice setting must sign the certification on the following page.*

Section 5: Certification

I certify that I am the person herein named subscribing to this application; that I have read the complete application, know the full content thereof, and declare under penalty of perjury, that all of the information contained herein and evidence or other credentials submitted herewith the true and correct. Further, I hereby authorized all lending institutions, or licensing agents, as authorized on my application for California licensure, to release to the Dental Board of California or its successors any information enumerated on my application for California licensure or for this loan repayment program. I understand that I may be asked to provide additional information in the future. If I am an award recipient under this educational loan repayment program, I understand that I will be required to sign a written agreement with the Dental Board of California outlining the provisions which must be met to fulfill my obligations under this program. I am free of any judgments or liens arising from State or Federal debt. I understand that falsification or misrepresentation of any item or response on this application or any attachment hereto is sufficient basis for denying this application, and may be grounds for discipline.

Signature of Applicant: _____ Date: _____

CERTIFICATION OF THE PRACTICE SETTING'S ADMINISTRATIVE OFFICER

The person signing this form may not be related to the applicant by blood, marriage, or adoption.

I certify that I am the Administrative Officer of the facility named in Section 4, Item 3, above, and that we have entered into an agreement with the person named on this application to provide services to us for a minimum of three years. Through the interview process, we have determined that the applicant can speak the Medi-Cal threshold language identified on this application. In accordance with California Code of Regulations, Title 16, Section 1042.2 (a) (8), we agree not to use the Program's award of educational loan repayments as a means to reduce the recipient's salary or offset those salaries (e.g., deduction of funds from paychecks, etc.). I certify that this clinic meets the definition of a practice setting as defined in California Business and Professions Code Section 1971 (h). I declare under penalty of perjury that these statements are true and correct.

Signed: _____

Printed Name: _____

Telephone Number: (_____) _____ - _____

Please mail the completed application and supporting documentation to:

Dental Board of California
Dental Loan Repayment Program
2005 Evergreen Street, Suite 1550
Sacramento, CA 95815

INFORMATION COLLECTION AND ACCESS

The information requested herein is mandatory and is maintained by Dental Board of California, 2005 Evergreen Street, Suite 1550, Sacramento, CA 95815, Executive Officer Karen Fischer (916) 263-2188, in accordance with Business & Professions Code, §1600 et seq. Except for Social Security numbers, the information requested will be used to determine eligibility. Failure to provide all or any part of the requested information will result in the rejection of the application as incomplete. Disclosure of your Social Security number is mandatory and collection is authorized by §30 of the Business & Professions Code and Pub. L 94-455 (42 U.S.C.A. §405(c)(2)(C)). Your Social Security number will be used exclusively for tax enforcement purposes, for compliance with any judgment or order for family support in accordance with Section 17520 of the Family Code, or for verification of licensure or examination status by a licensing or examination board, and where licensing is reciprocal with the requesting state. If you fail to disclose your Social Security number, you may be reported to the Franchise Tax Board and be assessed a penalty of $100. Each individual has the right to review the personal information maintained by the agency unless the records are exempt from disclosure. Applicants are advised that the names(s) and address(es) submitted may be made public.