

**DENTAL BOARD OF CALIFORNIA**

2005 Evergreen St., Suite 1550, Sacramento, CA 95815

P (916) 263-2300 | F (916) 263-2140 | www.dbc.ca.gov**DECLARATION AND REQUEST FOR REPLACEMENT POCKET LICENSE OR CERTIFICATE***Please type or print legibly***For Office Use Only:**

Amount _____ Receipt _____

File # _____ Date Processed _____

1. Full Legal Name: Last First Middle Suffix (if any):	2. License/Permit: Type and Number
3. For applicants seeking replacement due to name change: Name license was originally issued under (if different from above)	4. Date original license/permit was issued (MM,DD,YR)
5. Mailing Address:	6. Date of Birth:
7. Email Address (if any):	8. Telephone Number:

Request for Replacement of: (check appropriate box)

<input type="checkbox"/> Pocket License \$111 - Non-Refundable Fee	<input type="checkbox"/> Wall Certificate \$111 - Non-Refundable Fee
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I hereby request replacement of my wall certificate or pocket license for the following reason(s):

Reason for Request: (check appropriate box)

<input type="checkbox"/> Lost/Original Not Received	<input type="checkbox"/> Stolen	<input type="checkbox"/> Mutilated/Destroyed
<input type="checkbox"/> My Name Changed. Please issue me a replacement pocket license or wall certificate, as requested above, in the name listed in Box 1 of this form.		

I certify under penalty of perjury under the laws of the State of California that all of the information provided on this form is true and correct and that I am the person named on the license or permit stated above._____
Signature_____
Date**INFORMATION COLLECTION AND ACCESS**

This completed form, including all applicable fees, must be submitted to the Dental Board of California (Board) as required by Title 16, California Code of Regulations (CCR) sections 1012 and 1021 or your application will not be processed (16 CCR section 1004). The information requested on this form is mandatory and will be used to determine eligibility for issuance of a replacement pocket license or wall certificate. The information may be provided to other governmental agencies, or in response to a court order, subpoena, or public records request. You have a right of access to records containing personal information unless the records are exempted from disclosure pursuant to Civil Code section 1798.40. Individuals may obtain information regarding the location of their records by contacting the Board's Executive Officer at 2005 Evergreen Street, Suite 1550, Sacramento, CA 95815, Executive Officer, 916-263-2300.



APPLICATION TO INACTIVATE LICENSE

APPLICATION TO ACTIVATE LICENSE

Bus. & Prof. Code 462, 700-704, Title 16 CCR 1017.1

For Office Use Only

Approved-date notified _____

Disapproved-date notified _____

Please type or print legibly

Name of Licensee _____

Address _____

Birthdate _____ License Number _____

☐ I wish to inactivate my _____ License. I understand that I must continue to pay the board the required biennial license renewal fee; however, I need not comply with the continuing education requirement. Prior to reactivating my license, I will complete the required continuing education.

☐ I wish to activate my _____ License. I inactivated my license on _____. Attached to this request is evidence that I have completed the required number of approved continuing education courses within the last two years preceding this application, as required by the Dental Practice Act.

I certify under the penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Signature _____

Date _____

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, 916-263-2300, 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, under limited circumstances, be made public.



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APPLICATION TO ACTIVATE/ INACTIVATE LICENSE

Please type or print legibly

For Office Use Only: Approved Date _____
Disapproved Date _____

Full Legal Name of Licensee: Last First Middle Suffix (if any)	License Type and Number:
Email Address (if any):	Date of Birth:
Mailing Address:	
<div><input type="checkbox"/> I wish to ACTIVATE my license. By signing this document, I certify that I have completed at least the following applicable minimum continuing education (CE) units within the last two years preceding this application: <u>For dentists:</u> a minimum of 50 total CE units including the following mandatory coursework meeting the requirements of CCR sections 1016, 1017 or 1066:<ul style="list-style-type: none">• a course in Infection Control (2 units),• a course in the California Dental Practice Act (2 units),• completion of certification in Basic Life Support (maximum of 4 units),• a course on the responsibilities and requirements of prescribing Schedule II opioids (2 units),• for dentists prescribing and administering vaccine, at least 1 hour of immunization training,• for dentists with a general anesthesia permit, at least 24 hours of approved courses related to deep sedation or general anesthesia and an advanced cardiac life support course,• for dentists with a moderate sedation permit, at least 15 hours related to moderate sedation and medical emergencies, and,• for dentists with an oral conscious sedation permit, at least 7 hours related to oral conscious sedation of adult patients. <u>For Registered Dental Assistants (RDA), Registered Dental Assistants in Extended Functions (RDAEF), Dental Sedation Assistants (DSA), and Orthodontic Assistants (OA):</u> a minimum of 25 CE units including the following mandatory coursework meeting the requirements of CCR sections 1016, 1016.2, or 1017:<ul style="list-style-type: none">• a course in Infection Control (2 units),• a course in the California Dental Practice Act (2 units), and,• completion of certification in Basic Life Support (maximum of 4 units).</div>	

☐

I wish to **INACTIVATE** my license. I am not currently engaged in any activity for which an active license is required from the Dental Board of California under the provisions of the Dental Practice Act.

☐

Check this box indicating that you have read the following notice:

(1) Pursuant to Business and Professions Code section 702, a holder of an inactive license shall not do any of the following:

(a) Engage in any activity for which an active license or permit is required.

(b) Represent that they have an active license.

(2) Pursuant to Business and Professions Code section 703, a holder of an inactive license must still renew their license and pay the biennial renewal fee (as set forth in Title 16, California Code of Regulations section 1021) but need not comply with any continuing education requirements.

(3) Prior to reactivating your license, you will be required to complete continuing education equivalent to that required for a single license renewal period (see specific items noted above for activating a license).

(4) Per Business and Professions Code section 1718.3, a license not renewed for five years from the license expiration date cannot be renewed, restored, reinstated, or reissued.

I certify under penalty of perjury under the laws of the State of California that all information provided on this form is true and correct and that I am the person named above on this form.

Signature

Date

INFORMATION COLLECTION AND ACCESS

This completed form must be submitted to the Dental Board of California (Board) as required by Business and Professions Code sections 700-704, and Title 16, California Code of Regulations (16 CCR) section 1017.2 or your application will not be processed (16 CCR section 1004). The information requested on this form is mandatory and will be used to determine eligibility for activation or reactivation (restoration) of a license. The information may be provided to other governmental agencies, or in response to a court order, subpoena, or public records request. You have a right of access to records containing personal information unless the records are exempted from disclosure pursuant to Civil Code section 1798.40. Individuals may obtain information regarding the location of their records by contacting the Board's Executive Officer at 2005 Evergreen Street, Suite 1550, Sacramento, CA 95815, Executive Officer, 916-263-2300.