Print Form

STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS

STATE AND CONSUMER SERVICES AGENCY • ARNOLD SCHWARZENEGGER, GOVERNOR
DENTAL BOARD OF CALIFORNIA
2005 Evergreen Street, Suite 1550 Sacramento, CA 95815
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California Dental Corps
Loan Repayment Program
Application

Please READ all instructions carefully before completing this application. Please type or print neatly. All questions on this application must be answered and supporting documentation may be requested; however, please do not include any attachments other than what is requested. All attachments are considered part of the application.

Since this is a newly implemented program, you may be asked to provide additional information in the future. Falsification or misrepresentation on any item or response of this application or any attachment hereto is sufficient basis for denying this application.

California Dental Corps
Loan Repayment Program Application

Section 1: Personal Data		
Applicant Name:		
Home Address:		
City:	State:	Zip Code:
Home Phone:	Work Phone:	EXT:
U.S. Social Security Number:	Date of Birth:	
E-mail Address:		

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 an unrestricted license to practice dentistry in California?		
☐Yes	License #:	Date of initial issuance of this license:
☐ No	If you are not licensed to practice dentistry in California when you apply to the loan repayment program, you must ensure that your Application is submitted to the Dental Board promptly. In order to be eligible for participation in the loan repayment program, you must be licensed in California before the final filing date for the application period. If you are not licensed by the final filing date, this application will not be considered for this program.	
1a. Are you now, or have you ever been, licensed to practice dentistry in any other jurisdiction in the United States or Canada?		
☐Yes	In which jurisdiction	Date of initial issuance of this license
	In which jurisdiction	Date of initial issuance of this license
	In which jurisdiction	Date of initial issuance of this license
☐ No		
2. Do you speak a Medi-Cal threshold language(s)? (Applicants may be asked to provide certification of this linguistic ability at a later date.)		
☐ Yes	Which language(s)	☐ No
3. Have you received significant training in cultural and linguistically appropriate service delivery	☐ Yes	☐ No
Please describe your experience:		

4. 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 If yes, what language(s):
5. Do you have at least three years of experience working in a dentally underserved area(s)?	
6. How many years experience do you have working in a dentally-related health field located in a dentally under served area?	
_____ Years	
7. Have you successfully completed a postgraduate training program, in which you provided services to a population that speaks any Medi-Cal threshold language, and for how many years were you in this program?	
☐ No: I am currently in training	Years:
☐ Yes: general dentistry	Years:
☐ Yes: oral surgery	Years:
☐ Yes: pediatric dentistry	Years:
☐ Yes: orthodontic dentistry	Years:
☐ Yes: endodontic dentistry	Years:
☐ Yes: periodontic dentistry	Years:
☐ Yes: prosthedontic dentistry	Years:
☐ Yes: other specialty	Years:
(If you answered yes to any specialty training in Question 8, please continue with Question 9)	
8. if you are still currently in training, in what specialty?	
9. At which facility did you complete (or will you complete) the postgraduate training listed in Question 8?	
Facility Name:	Street Address:
City: State: Zip Code:	From:
Dates of Attendance: From	To:
10. Are you a specialist of a Board, recognized by the Commission on Dental Accreditation of the American Dental Association?	
☐ Yes, by the Board of	Date first certified:
☐ No	

11. 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
12. Will you be providing dental services at multiple practice settings?	☐ Yes	☐ No
13. Will you be providing services at a non-profit corporation of a community clinic?	☐ Yes	☐ No

Please provide a typed statement that discusses your background and experience regarding your interest in the program.

Part 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.)

Loan Company Name:	
Loan Company Name:	
Loan Company Name:	
Loan Company Name:	

Applicants must submit a current loan statement for each educational loan identified. Each statement must clearly indicate: 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.

2. Are you currently participating in any other educational loan repayment or loan reduction program(s)?

☐ Yes	If yes, Which program(s)?	☐ No

3. Have you ever been, or are you currently, in default of have judgement liens against you for any debt, including but not limited to, taxes or education assistance programs?

☐ Yes	If yes, Please attach full explanation.	☐ No