STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
BUSINESS, CONSUMER SERVICES, AND HOUSING AGENCY • GOVERNOR EDMUND G. BROWN JR.
DENTAL BOARD OF CALIFORNIA
2005 Evergreen Street, Suite 1550, Sacramento, CA 95815
P (916) 263-2300 F (916) 263-2140 | www.dbc.ca.gov

Disabled Dentist Application for Waver of 50% of License Renewal Fee

Business & Professions Code 1716.1

For Office Use Only

Fee $325.00_____Receipt#_____
Date Cashiered_____ Cashier's initials_____
Approved_____Denied_____Date_____

Name (First, Middle, Last) _____
Mailing Address (This address will be on file with the Dental Board of California and is public information.)

_____

_____

_____

Telephone Number FAX (If applicable) Social Security # CA dental license #

The following must be completed by your attending physician:

Description of disability and explanation as to how the disability prevents the applicant from practicing dentistry safely. Attach additional sheet(s) if necessary.

Approximate date disability began: _____ The disability is: ☐Temporary ☐Permanent
If temporary, give approximate date applicant will be able to return to practicing dentistry: _____
Attending Physician's Name: _____ Telephone #: _____
Attending Physician's address: _____
Street Number City State Zip
Attending Physician's License Number _____ State attending physician is licensed in: _____
Attending Physician's Signature _____ Date _____

I certify under penalty of perjury under the laws of the State of California that the information I have provided in this application, including supporting documents, is true and correct. I also understand that ***I will not be permitted to practice dentistry*** *until I pay the current renewal fee in full, and demonstrate that I am no longer disabled, or the disability no longer affects my ability to practice dentistry safely.*

_____ _____
Applicant's Signature Date

Information and Filing Instructions

Business and Professions Code 1716.1 provides a waiver of 50% of the renewal fee if a licensee demonstrates to the satisfaction of the Board that the licensee is unable to practice dentistry due to a disability. This waiver is at the discretion of the Board, may be terminated at any time, and is based on the licensee's inability to practice dentistry.

The licensee and his or her attending physician are required to complete the application. If the application is approved, the license will denote "Disabled." Biennially the license will receive a "License Renewal Application" to complete and sign. The reduced fee will be required to renew the exempt license. **The holder of a disabled license cannot engage in the practice of dentistry as that is defined in Bus. & Pro. Code 1625.**

At the time of application, if the applicant's dental license is expired, payment of all accrued renewal fees, the delinquent fee, and penalty fee must be submitted with the application. If the applicant's dental license has not expired, no fee is required.

When a license desires to return to practicing dentistry, the licensee and attending physician will be required to complete application to have the license removed from disabled status and returned to "active" licensure. It must be established to the satisfaction of the Board that the disability either no longer exists or does not affect the licensee's ability to practice dentistry safely. At the time of application, the licensee must also submit payment of the current (active license) renewal fee.

According to 16 CCR 1017(e), a licensee who has not practiced dentistry in California for more than one year because the licensee is disabled need not comply with the continuing education requirements of the article during the renewal period within which such disability falls. Such licensee shall certify that he/she is eligible for the waiver of the continuing education requirements. A licensee who ceases to be eligible for such waiver shall comply with the continuing education requirements for subsequent renewal periods.

I certify under penalty of perjury under the laws of the State of California that I read and understand the continuing education (CE) requirements for dentists. I have and can document (if audited) a minimum of 50 hours of approved CE units each biennial license renewal period, or that I am eligible for waiver of CE units for the Dental Board of California.

Applicant's 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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Applicant's License No._____ Issue Date_____ Expiration Date_____
If denied, provide reason:_____
Attending Physician's license verification: Number_____ Issue Date_____ Expiration Date_____
Dental Board Reviewer_____