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

ELECTIVE FACIAL COSMETIC SURGERY PERMIT APPLICATION (FCS)

Business and Professions Code, Section 1638.1 - 1638.5

FEES	*For Office Use Only*	*For Office Use Only*
Application Fee: $850.00 (Must be enclosed with application) **APPLICATION FEES ARE NON-REFUNDABLE**	Rec # _____ Fee Pd _____ Date Cashiered _____ Entity # _____ File # _____	Date Received

(PLEASE PRINT CLEARLY OR TYPE)

1. FULL NAME: LAST FIRST MIDDLE		2. SSN/ITIN:
3. ADDRESS OF RECORD:		
4. PRACTICE ADDRESS (If Different):		
5. BIRTH DATE (MM/DD/YYYY):	6. TELEPHONE NUMBER:	7. EMAIL ADDRESS:
8. CA DENTAL LICENSE NUMBER:	9. EXPIRATION DATE:	10. GENDER: MALE ☐ FEMALE ☐
11. DENTAL LICENSE NUMBER(S):	12. STATE(S) OF ISSUANCE:	

13. DO ANY OF THE FOLLOWING STATEMENTS APPLY TO YOU : YES ☐ NO ☐

- YOU WERE ADMITTED TO THE UNITED STATES AS A REFUGEE PURSUANT TO SECTION 1157 OF TITLE 8 OF THE UNITED STATES CODE;
- YOU WERE GRANTED ASYLUM BY THE SECRETARY OF HOMELAND SECURITY OF THE UNITED STATES ATTORNEY GENERAL PURSUANT TO SECTION 1158 OF TITLE 8 OF THE UNITED STATES CODE; OR,
- YOU HAVE A SPECIAL IMMIGRANT VISA AND WERE GRANTED A STATUS PURSUANT TO SECTION 1244 OF THE PUBLIC LAW 110-181, PUBLIC LAW 109-163, OR SECTION 602(b) OF TITLE VI OF DIVISION F OF PUBLIC LAW 111-8, RELATING TO IRAQUI AND AFGHAN TRANSLATORS/INTERPRETERS OF THOSE WHO WORKED FOR OR ON BEHALF OF THE UNITED STATES GOVERNMENT.
- IF YOU SELECTED YES, YOU MUST ATTACH EVIDENCE OF YOUR STATUS AS A REFUGEE, ASYLEE, OR SPECIAL IMMIGRANT VISA HOLDER. FAILURE TO DO SO MAY RESULT IN APPLICATION REVIEW DELAYS.

ACCEPTABLE DOCUMENTATION

- FORM I-94, ARRIVAL/DEPARTURE RECORD, WITH AN ADMISSION CLASS CODE SUCH AS “RE” (REFUGEE) OR “AY” (ASYLEE) OR OTHER INFORMATION DESIGNATING THE PERSON A REFUEE OR ASYLEE.
- SPECIAL IMMIGRANT VISA THAT INCLUDES THE “SI” OR “SQ”
- PERMANENT RESIDENT CARD (FORM I-551), COMMONLY KNOWN AS A “GREEN CARD,” WITH A CATEGORY DESIGNATION INDICATING THAT THE PERSON WAS ADMITTED AS A REFUGEE OR ASYLEE.
- AN ORDER FROM A COURT OF COMPETENT JURISDICTION OR OTHER DOCUMENTARY EVIDENCE THAT PROVIDES REASONABLE ASSURANCE THAT THE APPLICANT QUALIFIES FOR EXPEDITED LICENSURE.

14. ARE YOU REQUESTING EXPEDITING OF THIS APPLICATION FOR SPOUSES OR DOMESTIC PARTNERS OF AN ACTIVE-DUTY MEMBER OF THE U.S. ARMED FORCES? YES ☐ NO ☐

MILITARY SPOUSE OR DOMESTIC PARTNER REQUIREMENTS

NOTE: IF YOU MEET MILITARY SPOUSE OR DOMESTIC PARTNER REQUIREMENTS PLEASE SCAN AND ATTACH THE FOLLOWING DOCUMENTATION ON THE ATTACHMENTS PAGE OF THIS APPLICATION (YOU MAY BE ASKED TO SUBMIT ORIGINAL DOCUMENTATION):

- CERTIFICATE OF MARRIAGE OR DOMESTIC PARTNERSHIP OR OTHER LEGAL UNION WITH AN ACTIVE-DUTY MEMBER OF THE ARMED FORCES OF THE UNITED STATES WHO IS ASSIGNED TO A DUTY STATION IN THIS STATE UNDER OFFICIAL ACTIVE-DUTY MILITARY ORDERS.
- VERIFICATION OF CURRENT LICENSE IN ANOTHER STATE, DISTRICT, OR TERRITORY OF THE UNITED STATES IN THE PROFESSION OF VOCATION FOR WHICH YOU ARE SEEKING LICENSURE.

15. ARE YOU REQUESTING EXPEDITING OF THIS APPLICATION FOR HONORABLY DISCHARGED MEMBERS OF THE U.S. ARMED FORCES? YES ☐ NO ☐

MILITARY HONORABLE DISCHARGE REQUIREMENTS

NOTE: IF YOU MEET THE U.S. ARMED FORCES EXPEDITE REQUIREMENT, PLEASE SCAN AND ATTACH A COPY OF THE FOLLOWING DOCUMENTATION ON THE ATTACHMENTS PAGE OF THIS APPLICATION:

- DD214 OR OTHER SUPPORTING DOCUMENTATION.

Elective Facial Cosmetic Surgery Permit Qualifications

Please read the following questions and answer each one carefully to determine which pathway to licensure best matches your request for permit.

16. Are you certified or a candidate for certification by the American Board of Oral and Maxillofacial Surgery?

YES ☐ NO ☐ DATE COMPLETED:

NOTE: Please include proof of certification of completion of a CODA-approved residency program.

17. Do you have active status on the staff of a general acute care and that you maintain the necessary privileges based on the bylaws of the hospital to maintain that status.

YES ☐

NO ☐

NOTE: Please submit documentation showing proof of your active status.

18. Please select an application pathway option:

PATHWAY A: American Board of Oral and Maxillofacial Surgery Status:

NOTE: Enclose proof of certification or candidacy for certification by the American Board of Oral and Maxillofacial surgery.

DATE COMPLETED:	
RE-CERTIFICATION DATE:	
CANDIDATE FOR CERTIFICATION:	
RESIDENCY PROGRAM DIRECTOR OR FELLOWSHIP PROGRAM DIRECTOR:	

OPERATIVE REPORTS:

Submit documentation of at least 10 operative reports from residency training or proctored procedures that are representative of procedures that you intend to perform from the following categories:

CATAGORY I - Cosmetic contouring of the osteocartilaginous facial structure, which may include, but is not limited to, rhinoplasty and otoplasty.

CATAGORY II - Cosmetic soft tissue contouring or rejuvenation, which may include, but is not limited to facelift, blepharoplasty, facial skin resurfacing, or lip augmentation.

SURGICAL PRIVILEGES:

Submit documentation showing all of the surgical privileges that you possess at any licensed general acute care hospital and any licensed outpatient surgical facility in this state.

I am requesting an unlimited permit for:

CATAGORY I ☐ CATAGORY II ☐

PATHWAY B: Specific Surgical Privileges

NOTE: Enclose proof of completion of an oral and maxillofacial surgery residency program accredited by the Commission on Dental Accreditation of the American Dental Association.

OPERATIVE REPORTS:

Submit documentation of at least 10 operative reports from residency training or proctored procedures that are representative of procedures that you intend to perform from the following categories:

CATAGORY I - Cosmetic contouring of the osteocartilaginous facial structure, which may include, but is not limited to, rhinoplasty and otoplasty.

CATAGORY II - Cosmetic soft tissue contouring or rejuvenation, which may include, but is not limited to facelift, blepharoplasty, facial skin resurfacing, or lip augmentation.

HOSPITAL PRIVILEGES:

Submit documentation showing privileges by the medical staff at a licensed general acute care hospital to perform the surgical procedures at that hospital.

I am requesting an unlimited permit for:

CATAGORY I ☐ CATAGORY II ☐

Certification - *I certify under the penalty of perjury, under the law of the State of California that the information in this application and any attachments are true and correct.*

_____ _____

APPLICANT SIGNATURE **DATE**

INFORMATION COLLECTION AND ACCESS

All items in this application are mandatory.

Failure to provide any of the requested information will delay the processing of your application and will result in the application being rejected as incomplete.

The information provided will be used to determine your eligibility for licensure per sections 1628, 1628.5, 1629 and 1632 of the California Business and Professions Code (BPC) and Title 16, California Code of Regulations section 1028, which authorizes the collection of this information.

The information on your application may be transferred to other governmental or law enforcement agencies to perform their statutory or constitutional duties, or otherwise transferred or disclosed as provided in California Civil Code section 1798.24. Disclosure of either your Social Security Number (SSN) or Individual Taxpayer Identification Number (ITIN) is mandatory, and collection is authorized by BPC section 30 and 42 U.S.C.A. § 405(c)(2)(C). Your SSN or ITIN 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.

You have the right to review your application and your files except information that is exempt from disclosure as provided in the California Public Records Act (Gov. Code, §§ 7920.000 and following) or as otherwise provided by Civil Code section 1798.40 of the California Information Practices Act (Civ. Code, §§ 1798 and following).

Information provided on this application may be disclosed to a member of the public, upon request, under the California Public Records Act or pursuant to court order, subpoena, or search warrant. The address of record you list on this application is a public record and will be disclosed on the Board's website and otherwise be made available to the public if and when you become licensed. Individuals using a P.O. Box as their address of record are required to provide a physical (street) address to the Board that will not be disclosed to the public pursuant to a public records request or posted on the Board's website.

The Executive Officer is responsible for maintaining the information collected on this application form and may be contacted at 2005 Evergreen Street, Suite 1550, Sacramento, CA 95815, telephone number (916) 263-2300 regarding questions about this notice or access to records.

The Board is required to notify you that under BPC sections 31 and 494.5, the State California Department of Tax and Fee Administration (CDTFA) and the Franchise Tax Board (FTB) may share taxpayer information with this Board. You are required to pay your state tax obligation. This application may be denied, or your license may be suspended if you have a state tax obligation, the state tax obligation is not paid, and your name appears on the CDTFA or FTB certified list of 500 largest tax delinquencies.