Indiana Limited Voluntary Charitable Permit instructions For Indiana
Your *best* Pathway to Health Dentists/Hygienist
April 8-10, 2020

Step #1 FILL OUT THE APPLICATION – Review the instructions attached and complete the application (attached). For the limited voluntary charitable permit there are several differences from the typical license application.

- Location of the Charitable Services should be completed on page 2 with *Sponsor/Name of facility:* Your *best* Pathway to Health - Lucas Oil Stadium April 8-10, 2020
  Address: 1202 E 38th St, Indianapolis, IN 46205
  Telephone: 317-927-7500
- Proof of current malpractice coverage needs to be included
- Answer the seven questions on page 3
- Include your signature three times on page 4

Step #2 CREATE YOUR COVER LETTER EXPLAINING THE REASON FOR THE CHARITABLE LICENSE- A sample is included

Step #3 SEND TO THE INDIANA STATE BOARD OF DENTISTRY FOR VERIFICATION- You need to send application and cover letter to the ISBD ASAP.

Step #4 RECEIVE YOUR TEMPORARY CHARITABLE LICENSE- Upon issuance of your permit the board will email you notification and instructions on how to download your permit. There is no cost associated with the permit. The charitable permit is good for 60 days.

Indiana State Board of Dentistry Contact Information:
Cindy Vaught, Board Director
Heather Hollcraft, Assistant Director

Staff Phone: (317) 234-2054
Staff Email: pla8@pla.in.gov
Agency Fax: (317) 232-2960

Professional Licensing Agency
Attn: Indiana State Board Of Dentistry
402 W. Washington Street, Room W072
Indianapolis, Indiana 46204

Professional Licensing Agency
402 West Washington Street
Room W072
Indianapolis, Indiana 46204

Michael R. Pence
Governor of Indiana
Nicholas W. Rhoad
PLA Executive Director

STATE BOARD OF DENTISTRY
APPPLICANTS FOR A LIMITED VOLUNTARY CHARITABLE PERMIT
INFORMATION AND INSTRUCTIONS
IND. CODE 25-13-1-4.5 DENTAL HYGIEINISTS
IND. CODE 25-14-1-5.7 DENTISTS

Before completing and submitting your application to our office, please read all materials and information included.

APPLICATION AND INFORMATION

Applicants will need the following documents and information:

1. Application For Limited Voluntary Charitable Permit
2. Information and Instruction Sheet
3. Statutes and Administrative Rules which pertain to the practice of dentistry and dental hygiene

IPLA ADDRESS/PHONE NUMBER/FAX/EMAIL/WEBSITE

Indiana Professional Licensing Agency
402 West Washington Street, Room W072
Indianapolis, Indiana 46204
Staff Phone: (317) 234-2054
FAX #: (317) 233-4236
Staff Email: pla8@pla.in.gov
Website: www.pla.in.gov

THE FAIR INFORMATION PRACTICE ACT

In compliance with Ind. Code 4-1-6, this agency is notifying you that you must provide the requested information, or your application will not be processed. You have the right to challenge, correct, or explain information maintained by this agency. The information you provide will become public record. Your examination scores and grade transcripts are confidential except in circumstances where their release is required by law, in which case you will be notified.

MANDATORY DISCLOSURE OF U.S. SOCIAL SECURITY NUMBER

Your social security number is being requested by this state agency in accordance with Ind. Code 4-1-8-1, 25-1-5-11(a), and 828 IAC 1-1-2(d). Disclosure is mandatory, and this record cannot be processed without it.

Failure to disclose your U.S. social security number will result in the denial of your application. Application fees are not refundable.

PROOF OF MALPRACTICE INSURANCE

In accordance with 25-13-1-4.5 and 25-14-1-5.7 a dentist or dental hygienist must provide proof that either:

(A) The individual; or
(B) The clinic at which the individual will practice;

Has malpractice insurance that covers the individual.

PROVIDING DENTAL CARE WITHOUT COMPENSATION

In accordance with Ind. Code 25-13-1-4.5 and 25-14-1-5.7, a dentist or dental hygienist must plan to provide, without compensation, dental care to individuals who are indigent, in critical need, or uninsured.

CONTROLLED SUBSTANCES

The dentist practicing under a permit issued under Ind. Code 25-14-1-5.7 may not distribute, dispense, or administer a controlled substance.

PERMIT EXPIRATION

A permit issued under Ind. Code 25-13-1-4.5 and 25-14-1-5.7 expires sixty (60) days after issuance of the permit.

ISSUANCE OF PERMIT

Upon issuance of your permit by the Board, you will be sent an email notifying you that your permit has been issued. There will be instructions on how to download a free permit card for immediate printing.

This service will be available at Services.IN.gov/License Express on our website at www.pla.IN.gov.

INSTRUCTIONS

All applicants must submit an application and supporting documentation to:

Indiana Professional Licensing Agency
ATTN: Indiana State Board of Dentistry
402 West Washington Street, Room W072
Indianapolis, Indiana 46204

1. APPLICATION

Complete, typewritten (or legibly printed) application.

2. PROOF OF MALPRACTICE INSURANCE

A dentist or dental hygienist must provide proof that either:
(A) The individual; or
(B) The clinic at which the individual will practice;
Has malpractice insurance that covers the individual.

3. AFFIDAVIT

If you answer "yes" to any of the twelve (12) questions on the application, the applicant must explain fully in a signed and notarized affidavit, meaning an explanation or statement of facts and or events, including all related details. Describe the event including location, date and disposition. If you have a malpractice action, provide name(s) of plaintiff(s). Letters from attorneys or insurance companies are not accepted in lieu of your statement; however, they may accompany your affidavit.

If the applicant has been ***arrested; entered into a prosecutorial diversion or deferment agreement; convicted; pled guilty to or pled nolo contendre to any offense, misdemeanor, or felony in any state***, except for minor violation of traffic law resulting in fines, and arrests or convictions that have been expunged by a court, the applicant shall submit a notarized statement detailing all criminal offenses, excluding minor traffic violations. The notarized statement must include the following information:

(1) The date(s), location(s), court, and cause number.
(2) The offense, misdemeanor or felony of which the applicant was arrested for, entered into a prosecutorial diversion or deferment agreement; convicted, pled guilty to or pled nolo contendre to.
(3) The penalty imposed.

Also, included with your notarized statement, you will need to provide copies of any and all court documentation regarding each offense listed.

APPLICATION FOR A LIMITED VOLUNTARY CHARITABLE PERMIT FOR DENTISTRY OR DENTAL HYGIENE

STATE BOARD OF DENTISTRY
PROFESSIONAL LICENSING AGENCY
402 West Washington Street, Room W072
Indianapolis, Indiana 46204
Telephone: (317) 234-2054
Email: pla8@pla.in.gov
www.pla.in.gov

*Your Social Security number is requested by this agency in accordance with IC 4-1-8-1, and it is mandatory that it be given.

FOR OFFICE USE ONLY	
Applicant number	
Permit number	
Permit issuance date (month, day, year)	
Permit expiration date (month, day, year)	

DO NOT WRITE ABOVE THIS LINE.

APPLICANT INFORMATION

Name of applicant (last, first, middle, maiden)	Social Security number*	
Address (number and street or rural route number)		
City	State	ZIP code
Date of Birth	Place of Birth	
Telephone number	E-mail address	

TTYPE OF PERMIT

☐ Dentist ☐ Dental Hygienist

BASIS OF PERMIT

In accordance with Ind. Code 25-13-1-14.5(a)(1)(A) & (B) and 25-14-1-5.7 (a)(1)(A) & (B), an applicant must have one (1) of the following in order to be issued a limited voluntary charitable permit. Please check the basis for which you are applying.

☐ Holds an inactive Indiana dental or dental hygiene license.

☐ Licensed as a dentist or dental hygienist in another state and is in good standing with that state's licensing agency.

State licensed	License number	Issuance date	Expiration date

DEGREE GRANTED BY

Name of School	Location of school
Degree granted	Date of graduation

LOCATION OF CHARITABLE SERVICES

Please list the location(s) of where the charitable services will be provided

Sponsor/Name of Facility **Your *Best* Pathway to Health - Mobile Multispecialty Clinic - Lucas Oil Stadium**		
Address 500 S. Capitol Avenue		
City Indianapolis	State IN	Zip Code 46225
Telephone Number 317-262-8600		

MALPRACTICE INSURANCE

An applicant must provide proof that either:

(a) the individual; or

(b) the clinic at which the individual will practice;

has malpractice insurance that covers the individual.

(Please provide a copy of the policy as proof of the malpractice coverage.)

Type of Coverage

☐ Individual ☐ Clinic

Name of Malpractice Insurance Carrier	Policy Number

QUESTIONS

If you answer "yes" to any of the following questions on the application, the applicant must explain fully in a signed and notarized affidavit, meaning an explanation or statement of facts and or events, including all related details. Describe the event including location, date and disposition. If you have a malpractice action, provide name(s) of plaintiff(s). Letters from attorneys or insurance companies are not accepted in lieu of your statement; however they may accompany your affidavit.

If the applicant has been ***arrested; entered into a prosecutorial diversion or deferment agreement; convicted; pled guilty to or pled nolo contender to any offense, misdemeanor, or felony in any state***, except for minor violation of traffic law resulting in fines, and arrests or convictions that have been expunged by a court, the applicant shall submit a notarized statement detailing all criminal offenses, excluding minor traffic violations. The notarized statement must include the following information:

(1) The date(s), location(s), court, and cause number.
(2) The offense, misdemeanor or felony of which the applicant was arrested for, entered into a prosecutorial diversion or deferment agreement; convicted, pled guilty to or pled nolo contender to.
(3) The penalty imposed.

Also, include with your notarized statement, copies of any and all court documentation regarding each offense listed.

1. Has disciplinary action ever been taken regarding any health license, certificate, registration or permit you hold or have held?	☐ Yes ☐No
2. Have you ever been denied a license, certificate, registration or permit to practice dentistry or dental hygiene or any regulated health occupation in any state (including Indiana) or country, or surrendered your license?	☐ Yes ☐No
3. *Except for minor violations of traffic laws resulting in fines, and arrests or conviction that have been expunged by a court,* (1) have you ever been arrested; (2) have you ever entered into a prosecutorial diversion or deferment agreement regarding any offense, misdemeanor, or felony in any state; (3) have you ever been convicted of any offense, misdemeanor, or felony in any state; (4) have you ever pled guilty to any offense, misdemeanor, or felony in any state; or (5) have you ever pled nolo contender to any offense, misdemeanor, or felony in any state.	☐ Yes ☐No
4. Do you have any condition or impairment (including a history of alcohol or substance abuse) that currently interferes, or if left untreated may interfere, with your ability to practice in a competent and professional manner?	☐ Yes ☐No
5. Have you ever been denied staff membership or privileges in any hospital or health care facility or had such membership or privileges revoked, suspended or subjected to any restrictions, probation or other type of discipline or limitations?	☐ Yes ☐No
6. Have you ever been admonished, censured, reprimanded or requested to withdraw, resign or retire from any hospital or health care facility in which you have trained, held staff membership or privileges or acted as a consultant?	☐ Yes ☐No
7. Have you ever had a malpractice judgment against you or settled any malpractice action?	☐ Yes ☐No

I understand the following, as a holder of a limited voluntary charitable permit, issued under Ind. Code 24-13-1-4.5 and 24-14-1-5.7 that:

- A dentist or dental hygienist must plan to provide, without compensation, dental care to individuals who are indigent, in critical need, or uninsured.
- A dentist practicing under a permit may not distribute, dispense or administer a controlled substance.
- A permit expires sixty (60) days from the date of issuance.

Signature of applicant	Date signed (month, day, year)

APPLICATION AFFIRMATION

I hereby swear or affirm, under the penalties of perjury, that the statements made in this application are true, compete and correct.

Signature of applicant	Date (month, day, year)

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorized, request and direct any person, firm officer, corporation, association, organization or institution to release to the Professional Licensing Agency any files, documents, records or other information pertaining to the undersigned requested by the Agency, or any of its authorized representatives in connection with processing my application for a limited voluntary charitable permit.

I hereby release the aforementioned persons, firms, officers, corporations, associations, organizations and institutions from any liability with regard to such inspection or furnishing of any such information.

I further authorize the Professional Licensing Agency to disclose to the aforementioned organizations, persons, and institutions from any information which is material to my application, and I hereby specifically release the Agency and Board from any and all liability in connection with such disclosure.

A photo static copy of this authorization has the same force and effect as the original.

AFFIRMATION

I hereby swear or affirm that I have read the above statements and agree to same.

Signature of applicant	Date signed (month, day, year)

Sample Cover Letter

February 15, 2020

Professional Licensing Agency
Attn: Indiana State Board Of Dentistry
402 W. Washington Street, Room W072
Indianapolis, Indiana 46204

Dear Indiana State Board of Dentistry staff,

I am writing to request a Limited Voluntary Charitable permit in order for me to participating in the Your *best* Pathway to Health charitable event on April 8-10 2020 at the Lucas Oil Stadium, Indianapolis, IN. I am volunteering my time to perform dental education, screenings, and general dentistry care for no compensation to individuals, who are indigent, in critical need, and or underinsured.

Please find included completed and signed application, proof of current malpractice coverage.

If you have any questions, please contact me at …….

Sincerely,

Dr. …..