MONTANA BOARD OF DENTISTRY
PO BOX 200513
(301 S PARK, 4TH FLOOR - Delivery)
Helena, Montana 59620-0513
(406) 841-2390 or 2331 FAX (406) 841-2305
EMAIL: dlibsdden@mt.gov WEBSITE: www.dentistry.mt.gov

REQUEST FOR REACTIVATION OF AN EXPIRED LICENSE

NAME: _____ MONTANA LICENSE NUMBER: _____

DENTIST ☐ DENTAL HYGIENIST ☐ DENTURIST ☐

Year last renewed: _____

Renewal Fee: _____ Date _____ Penalty Fee: _____

Dentist Renewal fee: $153.00 Dental Hygienist Renewal fee: $70.00 Denturist Renewal Fee: $100.00

Penalty fee for each year is 100% of the renewal fee. If reactivating for two years, the penalty fee will be 200% of the renewal fee.

In order to reactivate your license, the above fees must be submitted with the application.

How long has your license been lapsed (non-renewed) in Montana? _____

Are you practicing in another State? _____

Please list the State or States that you have practiced in:

_____ _____

_____ _____

_____ _____

Please provide license verification from the State Regulatory Boards of the state/states that you have listed above. (Must come directly from the state agency).

How long have you been out of practice in your profession? _____

Please Submit:
Current copy of your CPR card
60 hours of continuing education certificates for dentists in the last three years
36 hours of continuing education certificates for dental hygienists in the last three years
36 hours of continuing education certificates for denturists in the last three years

Please indicate why you are requesting reactivation of your license in Montana:

_____

_____

_____

_____

_____

☐ Yes ☐ No Have you had any discipline instituted or taken against your license in another state, been denied licensure or have had any civil action pending or completed?

Signature _____ Date _____

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CERTIFICATION OF HOURS
FOR REINSTATEMENT OR REACTIVATION

NAME: _____

DATE: _____

EMPLOYER NAME: _____

DATES WORKED: from _____ to: _____

☐ Full Time ☐ Part Time Hours per week _____

EMPLOYER SIGNATURE: _____ DATE: _____

If you have had more than one employer during this period of time, the applicant must have one form signed by each employer verifying work experience. You may make copies of this form.

Employer's Address _____

City _____ State _____ Zip Code _____

Phone Number _____

I hereby certify that the information submitted on this form is true and complete to the best of my knowledge. In signing this form, I am aware that a false statement or evasive answer may lead to denial of my application or subsequent revocation of licensure on ethical grounds.

Applicant Signature: _____

Date: _____