THE STATE of ALASKA
Department of Commerce, Community, and Economic Development
Division of Corporations, Business and Professional Licensing

Board of Dental Examiners
PO Box 110806, Juneau, AK 99811
Phone: (907) 465-2550
Email: *BoardOfDentalExaminers@Alaska.Gov*
Website: *ProfessionalLicense.Alaska.Gov/BoardOfDentalExaminers*

Temporary Dental Permit Application Instructions

Except as provided in AS 08.36.238 and 08.36.254, a person may not practice, or attempt to practice, dentistry without a license. A temporary permit to practice dentistry may only be used for the purpose of substituting for an incapacitated dentist licensed in the state of Alaska. A temporary permit is valid only to treat patients of the incapacitated dentist at an address listed on the business license of the incapacitated dentist. A temporary permit cannot be issued if another dentist licensed in Alaska may reasonably substitute for the incapacitated dentist. An "incapacitated" dentist is defined as impaired by a health condition that renders a dentist unable to practice dentistry for more than 30 days.

A temporary permit may be issued for 90 consecutive days and is authorized only for the practice locations of the incapacitated dentist. The permit will show the name, license number, and practice locations of the incapacitated dentist.

Upon request, the permit will be extended for an additional 60 days if, before the expiration date of the initial 90-day permit, the applicant submits a completed full dental license application (#08-4159) and fees. The Board of Dental Examiners may refuse to grant the request for an extension for the same reasons the board may revoke a license under AS 08.36.315. Permits and extensions of permits are not valid for more than 240 calendar days during any consecutive 24 months unless as allowed under AS 08.36.254(g).

To qualify for a temporary dental permit, the applicant may not have had a license to practice dentistry revoked, suspended, or voluntarily surrendered in this state or another state or territory of the United States.

The following must be received by the division before your application for Temporary Dental Permit can be reviewed:

1. APPLICATION
A completed, signed, and notarized application (#08-4789).

2. FEES
Fees made payable to "State of Alaska."

Nonrefundable Application Fee:	$ 50.00
Temporary Permit Fee:	$112.50
Prescription Drug Monitoring Program (PDMP):	$ 0.00
Total Fees Due:	$162.50

3. INCAPACITATED DENTIST INFORMATION
An Incapacitated Dentist Information form (#08-4789a) completed by the incapacitated dentist, or an authorized representative of the incapacitated dentist, providing information regarding the reason for the incapacitation, and documentation of reasonable effort to find a substitute or authorized representative of the incapacitated dentist licensed in Alaska.

4. HEALTH CARE PROVIDER STATEMENT OF INCAPACITATION
A Health Care Provider Statement of Incapacitation form (#08-4789b) completed by the incapacitated dentist's healthcare provider verifying the dentist is incapacitated and unable to practice.

5. VERIFICATION OF LICENSURE
Verification of the applicant's current license to practice dentistry from a board of dental examiners of a U.S. state or territory of the U.S. The verification must include the applicant's status and complete information regarding any disciplinary action or investigation taken or pending on behalf of the applicant. The applicant should send the Verification of Licensure form (#08-4789c) to the U.S. state or territory to be completed and sent directly to the Alaska Board of Dental Examiners.

6. VERIFICATION OF EDUCATION

Verification of the applicant's graduation from a dental school that, at the time of graduation, was accredited by the Commission on Dental Accreditation of the American Dental Association by submitting either:

- A certified true copy of the applicant's dental school diploma showing credentials similar or equivalent to the incapacitated dentist's credentials;

– OR –

- Transcripts sent directly from the issuing educational institution showing credentials similar or equivalent to the incapacitated dentist's credentials.

7. NATIONAL PRACTITIONER DATA BANK REPORT – PULLED BY STAFF

Division staff shall request a National Practitioner Data Bank report on behalf of the applicant that shall be reviewed by the board with the application and supporting documentation.

Sec. 08.36.254. Temporary permit to substitute for an incapacitated dentist.

(a) The board may issue a temporary permit to practice dentistry to a dentist for the purpose of substituting for an incapacitated dentist licensed in this state.

(b) A dentist applying for a temporary permit under (a) of this section shall

(1) hold an active license from a board of dental examiners established under the laws of a state or territory of the United States issued after thorough examination;

(2) pay the required fee; and

(3) meet other qualifications for a temporary permit established by regulation.

(c) A temporary permit issued under this section is valid only to treat patients of the incapacitated dentist at an address listed on the business license of the incapacitated dentist.

(d) The fee for a permit issued under this section is one-fourth of the fee for a biennial license plus the appropriate application fee.

(e) The board may not issue a temporary permit under this section if another dentist licensed under this chapter may reasonably substitute for the incapacitated dentist.

(f) A temporary permit issued under this section is initially valid for 90 consecutive calendar days. Upon request of a permittee, the board shall extend a permit issued under this section for 60 calendar days if, before the expiration of the initial 90-day permit, the permittee submits to the board a completed application form and the fee required under this chapter, except that the board may refuse to grant a request for an extension for the same reasons the board may revoke a license under AS 08.36.315. Permits and extensions of permits issued to a permittee under this section are not valid for more than 240 calendar days during any consecutive 24 months.

(g) The board may extend a permit issued under this section for a period that exceeds the limit established in (f) of this section if the board determines that the extension is necessary to provide essential dental services and the board has received a clearance report from the

(1) National Practitioner Data Bank; and

(2) United States Drug Enforcement Administration.

(h) In this section, “incapacitated” means impaired by a health condition that renders a dentist unable to practice dentistry for more than 30 days.

12 AAC 28.954. TEMPORARY PERMIT.

(a) The board may issue a temporary permit to practice dentistry to a dentist who meets the requirements of this section for the purpose of substituting for a dentist the board has determined to be “incapacitated” as defined under AS 08.36.254.

(b) An applicant for a temporary permit under this section must submit to the department

(1) a complete, notarized application on a form provided by the department;

(2) the applicable fees in 12 AAC 02.190;

(3) a form completed by the incapacitated dentist or authorized representative of the incapacitated dentist providing information regarding the reason for the incapacitation and documentation of reasonable effort to find a substitute dentist licensed under this chapter;

(4) a form completed by the incapacitated dentist’s healthcare provider verifying the dentist is incapacitated and unable to practice;

(5) verification of the applicant’s current license to practice dentistry from a board of dental examiners of a state or territory of the United States; the verification must include the applicant’s status and complete information regarding any disciplinary action or investigation taken or pending on behalf of the applicant;

(6) verification of the applicant’s graduation from a dental school that at the time of graduation was accredited by the Commission on Dental Accreditation of the American Dental Association by submitting

(A) a certified true copy of the applicant’s dental school diploma showing credentials similar or equivalent to the incapacitated dentist credentials; or

(B) transcripts sent directly from the issuing educational institution showing credentials similar or equivalent to the incapacitated dentist credentials;

(c) The department shall request a report from the National Practitioner Data Bank on behalf of the applicant. The board will review the report as part of the application process and may deny a temporary permit application based on report content.

(d) An applicant for a temporary permit may not have had a license to practice dentistry revoked, suspended, or voluntarily surrendered in this state or another state or territory of the United States.

(e) The temporary permit issued will be authorized only for the practice locations of the incapacitated dentist. The name, license number, and practice locations of the incapacitated dentist will be printed on the license.

(f) The temporary permit will be extended past the initial 90 days if the applicant meets the requirements of AS 08.36.254(f) or (g) and pays the fee required in 12 AAC 02.190.

General Information

APPLICATION PROCESSING:
The average time to process a paper application varies by program but can take several weeks from the date it is received in this office complete with all correct forms, supporting documents and appropriate fees paid. When the application is complete and correct, and all supporting documents have been received and all fees have been paid, the license will be issued. Start the process far enough in advance to allow for processing time. Applications are reviewed in order of receipt in our office, and walk-in customers should not expect immediate review.

PROFESSIONAL FITNESS QUESTIONS:
A "yes" response in the application does not mean your application will be denied. If you have responded "yes" to any professional fitness questions in the application, be sure to submit a signed and dated explanation, and the charging document and judgement.

DENIAL OF APPLICATION:
Please be aware that the denial of an application of licensure may be reported to any person, professional licensing board, federal, state, or local governmental agency, or other entity making a relevant inquiry or as may be required by law.

RANDOM AUDIT:
If your program requires continuing education, the Division will audit a percentage of the license renewals. If your license is randomly selected for audit, a letter will be sent with instructions to submit documentation as proof you satisfied the continuing competency requirements as stated on this renewal form. Licensees are randomly selected by computer and may be randomly selected as often as the computer program chooses. You must save your documents for at least four years so you can respond to audits.

ADDRESS OR NAME CHANGE:
In accordance with 12 AAC 02.900, it is the applicant's/licensee's responsibility to notify the Division, in writing, of changes of address or name. Name and address change notification forms are available on the Division's website. The address of record with the division will be used to send renewals and all other official notifications and correspondence. The name appearing on the license must be your current legal name.

CERTIFIED TRUE COPIES:
If any of the required documents will be issued under a former name, indicate on the application and submit marriage license and/or court documents that are notarized as a "certified true copy of the original document". To obtain a certified true copy, you must present the notary with the original document along with the photocopy. You must write, "I certify this is a true copy of the original document" and sign your name. The notary will compare the original document with the copy and then notarize your signature.

SOCIAL SECURITY NUMBERS:
AS 08.01.060 and 08.01.100 require that a U.S. Social Security Number be on file with the division before a professional license is issued or renewed for an individual. If you do not have a U.S. Social Security Number, please complete the Request for Exemption from Social Security Number Requirement form (#08-4372) located at *ProfessionalLicense.Alaska.Gov* or contact the division for a copy of the form. This form is required with every application if you do not have a U.S. Social Security Number.

PUBLIC INFORMATION:
Please be aware that all information on the application form will be available to the public, unless required to be kept confidential by state or federal law. Information about current licensees, including mailing addresses, is available on the division's website at *ProfessionalLicense.Alaska.Gov* under License Search.

ABANDONED APPLICATIONS:
Under 12 AAC 02.910, an application is considered abandoned when 12 months have elapsed since correspondence was last received from or on behalf of the applicant. An abandoned application is denied without prejudice. At the time of abandonment, the division will send notification to the last known address of the applicant, who has 30 days to submit a written request for a refund of biennial license and other fees paid. The application fee will not be refunded. If no request for refund is received within that timeframe, no refund will be issued, and all fees will be forfeited.

BUSINESS LICENSES:
The status of a professional license will directly impact the status of an associated business license. Renewal applications for business licenses are mailed separately. For more information about business licenses, (907) 465-2550 or *BusinessLicense.Alaska.Gov*

STALE DOCUMENTS:
Application forms, authorizations and verifications older than 12 months from the date the document was received by the division will be considered stale; the document must be resubmitted as appropriate before the application will be considered by the division or a licensing board. Application documents include the application documents and verifications of licensure from other licensing jurisdictions. (12 AAC 02.915)

PAYMENT OF CHILD SUPPORT:
If the Alaska Child Support Enforcement Division has determined that you are in arrears on child support, you may be issued a nonrenewable temporary license valid for 150 days. Contact Child Support Services at (907) 269-6900 to resolve payment issues.

PRESCRIPTION DRUG MONITORING PROGRAM:
All actively licensed practitioners with a DEA registration number valid to use in any state or practice location must register with the Alaska Prescription Drug Monitoring Program (PDMP) within 30 days of initial licensure and use the PDMP to review a patient's prescription history each time before prescribing, administering, or dispensing a federally scheduled II or III controlled substance. For more information, please visit *PDMP.Alaska.Gov*

STATUTES AND REGULATIONS:
The complete set of statutes and regulations for this program are available by written request or online at the division's website: *ProfessionalLicense.Alaska.Gov*

If you would like to receive notice of all proposed regulation changes for your program, please send a request in writing with your name, preferred contact method (mail or email), and the specific program you want to be updated on to the address below.

Regulations Specialist
Department of Commerce, Community, and Economic Development
Division of Corporations, Business and Professional Licensing
EMAIL: *RegulationsAndPublicComment@Alaska.Gov*

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Temporary Dental Permit Application

PART I Payment of Fees

Required Fees:	☐ Nonrefundable Application Fee	**$ 50.00**
	☐ Temporary Permit Fee	**$112.50**
PDMP Fees:	☐ I have an active DEA registration number valid in any state or practice location.	**$ 0.00**
	☐ I do not have an active DEA registration number valid in any state or practice location.	**$ 0.00**

PART II Personal Information

Full Legal Name:			

Provide all other names used (maiden, nicknames, aliases). If any documentation will be received in a prior name, you must provide a certified true copy of the documentation showing proof of legal name change(s).

☐ Not Applicable

☐ Other Names Used: _____

Mailing Address:	P.O. Box or Street	City	State	Zip
Contact Phone:		**Date of Birth:**		

EMAIL AGREEMENT: By choosing to receive correspondence on any matter affecting my license or other business with the Alaska Division of Corporations, Business and Professional Licensing, I agree to maintain an accurate email address through the MY LICENSE web page. I understand that failure to check my email account or to keep the email address in good standing may result in an inability to receive crucial information, potentially resulting in my inability to obtain or maintain licensure.

Email Address:		**Select One:**	☐ Send my Correspondence Electronically ☐ Send my Correspondence by Mail

Note: If both boxes are selected above, you will receive correspondence electronically.

SOCIAL SECURITY NUMBER: AS 08.01.060 requires you to provide your United States Social Security Number. It is considered confidential information and will not be publicly disclosed; it may be used to verify inter-state licensure.	

PART III Dental Education Information

Name of Dental School:			
Location: (City, State)		**Date Passed National Board Exams:**	
Degree Awarded:		**Date Awarded:**	

To verify my graduation from a dental school that, at the time of graduation, was accredited by the Commission on Dental Accreditation of the American Dental Association, I will be submitting:

☐ A certified true copy of my dental school diploma showing credentials similar or equivalent to the incapacitated dentist's credentials;

- or -

☐ Transcripts sent directly from the issuing educational institution to the Alaska Board of Dental Examiners showing credentials similar or equivalent to the incapacitated dentist's credentials.

PART IV Professional License(s)

List the license number and name of the jurisdiction for all dental licenses you hold or have ever held in any jurisdiction (i.e., states, territories, provinces, or foreign countries). *Continue on a separate page, if necessary.*

State or Jurisdiction	Licensed By (Exam, Credential, Other)	License Number	Issue Date	Expiration Date

☐ I understand that I must have a verification of my current license to practice dentistry sent directly to the State of Alaska by a board of dental examiners of a U.S. state or territory, and that the verification must include my license status and complete information regarding any disciplinary action or investigation taken or pending on my behalf.

PART V Incapacitated Dentist Information

Name of Dentist:			
License Number:		**Business License Number(s):**	
Practice Address:	Street City State Zip		
Reason for Incapacitation:			

☐ I understand the incapacitated dentist must submit the Incapacitated Dentist Information form (#08-4789a) and the incapacitated dentist's health care provider must submit the Statement of Incapacitation form (#08-4789b).

PART VI DEA Registration and PDMP Acknowledgment

1. **Providers with a DEA registration number valid to use in any state or practice location must register with the Alaska Prescription Drug Monitoring Program (PDMP). Do you have a DEA Registration number?**

☐ **a.** **NO**, I do not have an active DEA registration number valid to use in any state or practice location. I understand if I obtain a DEA registration number, I must register with the Alaska PDMP within 30 days as required by the board. I will refer to all applicable authorizing statutes, regulations, and comply with mandatory use. (Skip to Part VII.)

☐ **b.** **YES**, I have an active DEA registration number valid to use in any state or practice location. I understand I must register with the Alaska PDMP within 30 days of receiving this license, as required by the board, and will comply with mandatory use as required by AS 17.30.200, 12 AAC 28.953, and 12 AAC 40.967.

☐ I acknowledge I must review a patient's prescription history prior to prescribing, administering, or dispensing a federally scheduled II or III controlled substance.

☐ I acknowledge that if I have a change in DEA registration number or status, I must promptly submit the DEA Registration Status Change Form (#08-4763).

If you're unsure of the DEA issue date, indicate January 1st of the estimated year.

DEA Registration Number:		**Issue Date:**		**Expiration Date:**	

2. **Providers who directly dispense a federally scheduled II - IV controlled substance are required to report to the PDMP daily. Do you plan to directly dispense?** Directly dispense means you deliver the substance directly to the user. Writing a prescription for a patient to fill at a pharmacy is NOT direct dispensing.

Reporting does not apply to you if you directly dispense an outpatient supply of 24-hours or less in practice locations exempt under AS 17.30.200(t). Exempted facilities include health care facilities (defined in AS 18.07.111 or AS 18.20.499), correctional facilities, inpatient pharmacies, and emergency departments.

Per AS 11.71.900(8) "dispense" means to deliver a controlled substance to an ultimate user or research subject by or under the lawful order of a practitioner, including the prescribing, administering, packaging, labeling, or compounding necessary to prepare the substance for that delivery; "dispenser" means a practitioner who dispenses.

☐ **a.** **YES**, I plan to directly dispense and acknowledge I must report daily per AS 17.30.200 and 12 AAC 52.865.

☐ **b.** **NO**, I do not plan to directly dispense and acknowledge that if I begin directly dispensing, I must report daily. (If you are not directly dispensing, the reporting criteria do not apply to you.)

PART VII Attestations

By my signature below in Part VIII, I attest to the following:

☐ I have never had a license to practice dentistry revoked, suspended, or voluntarily surrendered in Alaska or any other U.S. state or territory.

☐ Once the temporary dental permit is issued, I will only treat patients of the incapacitated dentist at an address listed on the business license of the incapacitated dentist.

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Notary Signature Page

PART VIII Notarized Signature

I hereby certify that I am the person herein named and subscribing to this application and that I have read the complete application, and I know the full content thereof. I declare that all of the information contained herein, and evidence or other documents submitted herewith are true and correct.

I further understand that all information on this form and supplied with this form will be available to the public, unless required to be kept confidential by state or federal law. By my signature below, I attest that all facts, statements, and answers contained in this application are true and correct; I am not omitting any information which might be of value to this board in determining my qualifications and character, whether it is called for or not. Such falsifications, omissions, or withholding shall serve as sufficient grounds for the suspension, cancellation, or revocation of my dental courtesy license even though it is not discovered until after issuance.

I hereby give permission to the Board of Dental Examiners to secure additional information concerning me or any statement in this application from any person or any source the board may desire. I further agree to submit to questioning by the board or any member thereof, and to substantiate any statements if desired by the board.

I have read the Alaska Dental & Dental Hygiene Practice Act. I solemnly declare upon my honor that, if granted a temporary permit in Alaska, I will respectfully comply with any law governing the practice of dentists and dental hygienists in this state and will do my best to uphold and maintain the ethics of the profession.

I understand that any falsification or misrepresentation of any item or response in this application, or any attachment hereto, or falsification or misrepresentation of documents to support this application, is sufficient grounds for denying, revoking, or otherwise disciplining a license or permit to practice in the state of Alaska.

I further understand that it is a Class A misdemeanor under Alaska Statute 11.56.210 to falsify an application and commit the crime of unsworn falsification.

A person who makes a false statement on this application may be subject to civil and criminal penalties, including prosecution for perjury (AS 11.56.200 & AS 11.56.230).

Notary Stamp				
	Applicant Printed Name:			
	Applicant Signature:			
	Notary Public for State of:		**Subscribed and Sworn to Before me on this Day:**	
	Notary Signature:		**My Commission Expires:**	

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Incapacitated Dentist Information

Per AS 08.36.254, the board may issue a temporary permit to practice dentistry to a dentist for the purpose of substituting for an incapacitated dentist in Alaska. The temporary permit is only valid to treat patients of the incapacitated dentist at an address listed on the business license of the incapacitated dentist. The board may not issue a temporary permit if another dentist licensed in Alaska may reasonably substitute for the incapacitated dentist. "Incapacitated" means impaired by a health condition that renders a dentist unable to practice dentistry for more than 30 days.

Applicant Name:	

→ **Dentist:** This form is to be completed by the incapacitated dentist or authorized representative. Please complete this bottom part for the applicant identified above and return the form directly to the Alaska State Board of Dental Examiners at the letterhead address or email.

Incapacitated Dentist Name:			
License Number:		**Business License Number(s):**	
Practice Physical Address:	Street / City / State / Zip		
Practice Mailing Address:	P.O. Box or Street / City / State / Zip		
Reason for Incapacitation:			
Initial Date of Incapacitation:		**Projected Length of Incapacitation:**	
Name of Health Care Provider:			

Please describe the effort you have made to locate an Alaska licensed dentist to substitute for you in your practice, prior to locating the dentist who is applying for a temporary permit under AS 08.36.254:

Notary Stamp	**Incapacitated Dentist Signature:** (or Authorized Representative)			
	Notary Public for State of:		**Subscribed and Sworn to Before me on this Day:**	
	Notary Signature:		**My Commission Expires:**	

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Health Care Provider Statement of Incapacitation

Applicant Printed Name:	
Incapacitated Dentist Printed Name:	
Incapacitated Dentist Signature: (or Authorized Representative)	

→ **Health Care Provider:** I am requesting this form be completed on my behalf for proof of my incapacitation to the Alaska State Board of Dental Examiners. Please complete this form and return it to me or my authorized representative.

Initial Date of Incapacitation:		**Projected Length of Incapacitation:**	
Briefly describe the manner of incapacitation and reasons for inability to practice as a dentist:			
Health Care Provider Name:		**License Number:**	
Phone Number:			
☐ I verify the dentist listed in the "incapacitated dentist printed name" field above is incapacitated and unable to practice dentistry.			
Health Care Provider Signature:		**Date Signed:**	

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Verification of Licensure

→ Applicant:

Please complete the identifying information below and forward a copy of this form to all states, territories, or jurisdictions where you currently are or have ever been licensed. *Make additional copies of this form, as needed.*

Applicant Name:		**Date of Birth:**	
Mailing Address:	P.O. Box or Street / City / State / Zip		
Applicant Signature:		**Date Signed:**	

→ Licensing Agency or State Board:

Please complete this bottom part for the applicant identified above and return the form directly to the Alaska State Board of Dental Examiners at the letterhead email or address.

Licensee Name: (As Shown in Your Records)		**State or Jurisdiction:**	
License Number:		**Periods of Lapse:**	☐ Yes ☐ No
Issued By:	☐ Exam ☐ Credentials ☐ Other (Please Specify): _____		
Original Issue Date:		**Expiration Date:**	

1. Has the license ever been revoked, suspended, placed on probation, or restricted in any way? ☐ Yes ☐ No

2. Is the licensee the subject of a pending disciplinary proceeding? ☐ Yes ☐ No

3. Has the licensee ever been the subject of an unresolved complaint, review procedure, or disciplinary action? ☐ Yes ☐ No

"Yes" Answers

If you answered "yes" to any question above, please attach a detailed explanation or documentation signed and dated by the person whose signature appears below.

Board Seal	**Signature:**		**Date Signed:**	
	Printed Name:		**Title:**	
	Email:		**Phone:**	

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Letter of Explanation for a Professional Fitness "Yes" Answer

Use this form only to explain and document any professional fitness "yes" answers. A "yes" answer is not necessarily disqualifying but concealing one may be.

Each "yes" answer requires a separate explanation and associated documentation. Submit all relevant documentation with this form, even if you have previously provided it.

- **Explanations** include full details, dates, locations, type of action, organizations or parties involved, and specific circumstances. If the space provided is insufficient, make additional copies as needed.
- **Documentation** includes copies of court orders, charging documents, board or license actions, decisions against your professional certification, satisfaction of consent agreements (fines paid, community service completed, off probation, etc.), and fitness to practice letters (statement from your provider that you are safe to practice if you check "yes" to any of the questions regarding mental or physical health, or drug or alcohol abuse or addiction).
- **Disciplinary actions** may include, but not be limited to, suspension, surrender, revocation, probation, academic probation, reprimand, censure, restricted license, limited license, conditioned license, or letters of counseling, concern, advice, warning, caution, admonishment, or reprimand.

If you have multiple "yes" answers or multiple incidents for any professional fitness question, you must use a separate copy of this form and provide a full explanation and documentation for each incident.

The contents of licensing files are public records. If you believe that the additional information you are attaching to explain a "yes" answer should be considered confidential, state that in the attachment. A request for confidentiality may or may not be granted according to state law.

☐ ⇦ **Write the professional fitness question number you are answering "yes" to in the box.**

Location of Incident:		**Date of Incident:**	
Explanation of Incident: When in doubt, disclose and explain. *Make copies as necessary.*			

Did you attach all applicable documents associated with this incident?

☐ Court Orders ☐ Consent Agreements ☐ Disciplinary Actions ☐ Charging Documents

☐ Court Records ☐ Fitness to Practice ☐ All Other Documentation Related to This Incident

☐ I have additional incidents for this "yes" answer, or "yes" answers to other Professional Fitness questions and have attached a separate copy of this form for each incident.

Full Name:		**Program:**	
Signature:		**Date Signed:**	

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Credit Card Payment Form

All major credit cards are accepted. For security purposes, do not email credit card information. Include this credit card payment form with your application.

Name of Applicant or Licensee: _____

Profession Type (e.g., Acupuncture):

License Number *(if applicable)*: _____

I wish to make payment by credit card for the following *(check all that apply)*: **AMOUNT**

- ☐ Application Fee: _____ _____
- ☐ License or Renewal Fee: _____ _____
- ☐ Other *(fine, exam, etc.)*: _____ _____

1. _____ _____
2. _____ _____

TOTAL: _____

Name *(as shown on credit card)*: _____

Mailing Address: _____

Phone Number: _____ Email *(optional)*: _____

Signature of Credit Card Holder: X _____

08-4438 Rev 12/06/2022 Credit Card Payment Form (all major cards accepted)

CREDIT CARD INFO: Your payment cannot be processed unless all fields are completed!

1. Credit Card Number: -
2. Expiration Date: -
3. Security Code: -

All 3 fields **MUST** be completed!

This section will be destroyed after the payment is processed.