



DEPARTAMENTO DE

# SALUD

GOBIERNO DE PUERTO RICO

SECRETARÍA AUXILIAR PARA LA REGULACIÓN

DE LA SALUD PÚBLICA

División de Licenciamiento de Médicos y

Profesionales de la Salud

**Junta Dental Examinadora**

## PUERTO RICO BOARD OF DENTAL EXAMINERS

### APPLICATION FOR EXAMINATION AND LICENSE TO PRACTICE THE PROFESSION OF DENTISTRY

#### AFFIDAVIT

Applicant's Full Name

Social Security No. XXX-XX-\_\_\_\_\_ identified by means of

Kind of Identification

Number

#### AND DULY SWEORN-----

States that he/she is the person referred to in this application, and that the statements contained herein are true in every respect; that the attached photograph is a true likeness of him/herself, and was taken within the last six (6) months.

Acknowledges that any false statement in this application or by way of attachment shall be sufficient grounds for the **PUERTO RICO BOARD OF DENTAL EXAMINERS** to deny said license, or to revoke a license after it has been granted, or to penalize a person for incurring in a false statement.

Authorizes the **PUERTO RICO BOARD OF DENTAL EXAMINERS** or any other person, employer, corporation, institution, agency, or public or private entity, to exchange any information required about his/her person or about his/her license status, as well as for expanding, clarifying or checking information offered in this application or by way of attachment.

\_\_\_\_\_  
Applicant's Signature

Sworn and subscribed BEFORE ME, on this \_\_\_\_\_ day of \_\_\_\_\_ in \_\_\_\_\_,  
Day Month / Year Town

**AFFIDAVIT NO:** \_\_\_\_\_

\_\_\_\_\_  
Notary's Signature

SELLO DE ASISTENCIA LEGAL

NOTARY'S  
SEAL

## PERSONAL INFORMATION

**APPLICANT'S NAME:** \_\_\_\_\_  
Paternal Surname \_\_\_\_\_ Maternal Surname \_\_\_\_\_ Name \_\_\_\_\_ Middle Name \_\_\_\_\_

**PERMANENT ADDRESS:** \_\_\_\_\_  
No. and Street \_\_\_\_\_ Community or Housing Development \_\_\_\_\_ Town \_\_\_\_\_ Zip Code \_\_\_\_\_

**POSTAL ADDRESS:** \_\_\_\_\_

**CONTACT INFO:** RES. PHONE \_\_\_\_\_ CELLULAR: \_\_\_\_\_

**EMAIL:** \_\_\_\_\_

**DESCRIPTION:** HEIGHT: \_\_\_\_\_ COLOR OF HAIR: \_\_\_\_\_ COLOR OF EYES: \_\_\_\_\_ WEIGHT: \_\_\_\_\_

ANY PARTICULAR FEATURE: \_\_\_\_\_

**DATE OF BIRTH:** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Month Day Year      **PLACE:** \_\_\_\_\_ / \_\_\_\_\_  
City State or Country

1. HAVE YOU SUFFERED OR ARE SUFFERING FROM ANY CONTAGIOUS DISEASE OR CONDITION? \_\_\_\_\_

\*If your answer is Yes, submit a medical certificate explaining the disease and its status on filing date of application.

2. ARE YOU A CITIZEN OF THE UNITED STATES? \_\_\_\_\_ If your answer is No, please indicate if you are:

NATURALIZED \_\_\_\_\_ or  RESIDENT \_\_\_\_\_  
Certificate Number \_\_\_\_\_ Card Number \_\_\_\_\_

3. HAVE YOU EVER CHANGED YOUR NAME OR LAST NAME? \_\_\_\_\_ If your answer is Yes, please indicate:

\_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Date and Place of change      Reason for change      Original Name and/or Last Name

4. HAVE YOU BEEN CONVICTED OF ANY CRIME? \_\_\_\_\_ If your answer is Yes, please indicate:

\_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Nature of Crime      Place and Date      Status

\*Please attach document(s) providing additional information if needed.

5. HAVE YOU EVER BEEN LICENSED TO PRACTICE DENTISTRY IN ANOTHER STATE OR COUNTRY? \_\_\_\_\_

\*If answer is (Yes) attach a separate sheet giving particulars, including license number, how licensed, date and number of years of practice in each jurisdiction and the present status of each, must submit a letter from the Licensing Board of each Jurisdiction, certifying of your good standing. This certification must be sent directly to our Board by the Certifying Office.

6. HAVE YOU EVER BEEN OFFICIALLY REPRIMANDED, YOUR LICENSE SUSPENDED OR REVOKED, DISMISSED FROM OR REFUSED THE RIGHT TO BE EXAMINED, OR REFUSED A LICENSE TO PRACTICE DENTISTRY? \_\_\_\_\_

\*If answer is (Yes), attach a separate sheet giving complete and full details supported by official records.

7. HAVE YOU READ CAREFULLY AND UNDERSTOOD FULLY THE LAWS AND REGULATIONS APPLICABLE TO LICENSURE EXAMINATIONS FOR THE PRACTICE OF DENTISTRY IN PUERTO RICO? \_\_\_\_\_

### UNIVERSITY BACKGROUND

#### EDUCATIONAL INSTITUTION

First Year \_\_\_\_\_  
Second Year \_\_\_\_\_  
Third Year \_\_\_\_\_  
Fourth Year \_\_\_\_\_  
Special Studies \_\_\_\_\_

#### STUDY PERIOD

Period \_\_\_\_\_  
Period \_\_\_\_\_  
Period \_\_\_\_\_  
Period \_\_\_\_\_  
Period \_\_\_\_\_

### DENTAL BACKGROUND

#### EDUCATIONAL INSTITUTION

First Year \_\_\_\_\_  
Second Year \_\_\_\_\_  
Third Year \_\_\_\_\_  
Fourth Year \_\_\_\_\_

#### STUDY PERIOD

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Degree Obtained \_\_\_\_\_

Educational Institution \_\_\_\_\_

Date \_\_\_\_\_

### MEDICAL CERTIFICATE

I, \_\_\_\_\_, physician authorized to practice in \_\_\_\_\_ by virtue of \_\_\_\_\_  
Name of physician in legible writing State/Country

license number \_\_\_\_\_, issued by \_\_\_\_\_, CERTIFY that I have examined \_\_\_\_\_  
License Number License Issuer

and can attest to his/her being in good health and free of \_\_\_\_\_  
Name of Applicant in legible writing

any disease or contagious condition.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Physician's Signature

**CERTIFICATION FROM THE DEAN OF THE SCHOOL OF ODONTOLOGY**

I, \_\_\_\_\_, **Dean of the School of Odontology of \_\_\_\_\_**,  
Dean's Name Name of Institution

**CERTIFY that \_\_\_\_\_ was admitted to this institution on \_\_\_\_\_**,  
Applicant's Name Admission Date

**and completed \_\_\_\_\_ years of study obtaining the degree of \_\_\_\_\_ on \_\_\_\_\_**,  
Years Degree Obtained Date of Graduation

**I also certify that the photo attached to this application corresponds to the applicant who said photo refers to and who was granted said degree in this institution.**

**INSTITUTION'S  
SEAL**

\_\_\_\_\_  
Date Dean's Signature

**APPLICANT'S GOOD MORAL CONDUCT AFFIDAVIT**

\_\_\_\_\_, **Social Security Number \_\_\_\_\_ and \_\_\_\_\_ identified**  
Name of Deponent Dentist

**by means of \_\_\_\_\_, \_\_\_\_\_, AND DULY SWORDN, CERTIFIES: that he/she is in possession of**  
Type of Identification Number

**dentist license number \_\_\_\_\_, issued by \_\_\_\_\_, of \_\_\_\_\_ ;**  
Name of Board of Examiners State or Country

**that he/she has been personally acquainted with \_\_\_\_\_, for as long as \_\_\_\_\_ years ; that**  
Name of Applicant

**he/she attests to his/her good moral conduct, and thus recommends him/her before the PUERTO RICO BOARD OF DENTAL EXAMINERS as a person qualified for the practice of the profession of DENTISTRY in Puerto Rico.**

\_\_\_\_\_  
Dentist's Address \_\_\_\_\_ Dentist's Signature \_\_\_\_\_

**Sworn and subscribed BEFORE ME, on this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_,**  
in \_\_\_\_\_.

**AFFIDAVIT NO: \_\_\_\_\_**

**NOTARY'S  
SEAL**

\_\_\_\_\_  
**Signature of Notary Public**

**ASSESSMENT CHECKLIST - FOR THE BOARD'S EXCLUSIVE USE ONLY**

**APPLICATION DATE OF RECEIPT:** \_\_\_\_\_

**THIS APPLICATION HAS BEEN:**

**APPROVED FOR EXAMINATION**

**DENIED**

**President**

**President**

**Member**

**Member**

**Member**

**Member**

**Member**

**Member**

**Date of Assessment**

**REASON:** \_\_\_\_\_

---

---

---

**Exam Approval Date**

**Issued License Number**

**Date of License**

## BOARD OF EXAMINERS OF DENTISTRY

### **REQUIREMENTS FOR PRACTICING THE PROFESSION OF ODONTOLOGY IN PUERTO RICO** **(Requirements applicable from February 22, 2008)**

Public Law Number 75 of August 1925, as amended, regulates the profession of DENTISTRY in Puerto Rico, and establishes the following requirements:

1. To file, before the Board of Examiners of Dentistry, the official application provided by said entity, filled out in all its parts.
2. To submit documents accrediting the identity of the applicant, who must be of legal age.
3. To hold a bachelor's in science diploma or its equivalent or a pre-dental training from a university recognized by the Council on Higher Education of Puerto Rico and a Dental Surgeon diploma or its equivalent issued by the School of Dentistry of the Medical Science Campus of the University of Puerto Rico, or by any other university or college, in which case the Board shall accept said academic record provided:
  - (a) the admissions requirements and the academic program for obtaining the diploma or its equivalent are analogous to those requested by the School of Odontology of the Medical Science Campus of the University of Puerto Rico for the same purpose. (See Pre-Dental Training Required from Dental Examination Applicants form.)
  - (b) the applicant took at least the last two (2) years of the study years required for issuing said diploma at a university or college that, on the opinion of the Board, and based on its local and international reputation, can be reasonably considered as being an adequate educational institution, comparable to the School of Odontology of the Medical Science Campus of the University of Puerto Rico, insofar as the teaching of said courses.
4. To approve theoretical and clinical examinations on the basic sciences and clinical disciplines determined by the Board for the purpose of testing the applicant's abilities.

### **DOCUMENTS TO BE FILED BY THE APPLICANT TOGETHER WITH THE APPLICATION FORM**

1. Official application filled out in all its parts, bearing a 2 X 2 recent high-quality photo adhered to the first page of the application. The photo must be in keeping with its purpose.
2. Original and Copy Birth Certificate (Puerto Rico's Birth Certificates issued after July 2010).
3. Criminal Record Certificate issued by the Police Department of Puerto Rico and/or the corresponding organism in the country of origin. (The Board may require both.) This document must have been issued within a term of 30 (30) days prior to filing date.
4. Proof of residence in Puerto Rico. Submit evidence of residence indicating that the applicant has been living in Puerto Rico for a period of six (6) months prior to the date of the license application.
5. Official transcript of credits to verify pre-dental training. Transcripts must be sent by the institution where the applicant completed said studies directly to the office of the Board. Those applicants with pre-dental studies from more than one educational institution must submit a transcription of credits from each institution.
6. Official transcription of credits and Graduate Certification in Dentistry must be sent by the institution where the applicant completed his/her doctorate directly to the office of the Board. The Graduate Certificate (completion letter from the Registrar) is required in addition to the Certificate of the Dean of the School of Odontology, which is a part of the application and must be signed by said officer.  
\*If the institution where the applicant completed his/her doctorate denies providing the Graduate Certification, the candidate must bring the original diploma and a copy of it.
7. **Payment of application dues, by ATM, VISA, MasterCard, or by money order payable to the Secretary of the Treasury of Puerto Rico. The amount of fifty dollars (\$50.00) (Not refundable) is required.**

## **GENERAL INFORMATION**

1. **INFORMATION BOOKLET:** All applicants must make sure to obtain the **INFORMATION BOOKLET FOR THE PRACTICE OF DENTAL SURGERY IN PUERTO RICO**, available in the office of the Board for five dollars (**\$5.00**) (**Not refundable**). This amount may be included in the payment of examination dues.
2. **THEORETICAL EXAMINATION:** The Board of Examiners of Dentistry employs the theoretical exams from the National Board of Dental Examinations of the American Dental Association (**NATIONAL BOARDS**) as the theoretical component of the final examination. The approval of these exams within a term of five (5) years prior to the filing of this application is required.  
**Applicants must show the outcome report. This document must be sent by the National Board directly to the office of the Puerto Rico Board of Dental Examiners.**
3. **CLINICAL EXAMINATION:** The Board makes use of the clinical exams of the "Council of Interstate Testing Agencies (CITA)" as the clinical component of the final examination.  
Applicants who have been approved said exams must show the outcome report. This document must be sent by the "Council of Interstate Testing Agencies (**CITA**)" or **ADEX**, directly to the office of the Board of Examiners of Dentistry.
4. **ETHICS AND JURISPRUDENCE EXAMINATION:** The final examination includes an Ethics and Jurisprudence Examination to be offered by the Board on a twice-a-year call.
5. No application shall be processed until ALL documents accrediting the applicant's compliance with all the admissions requirements, as listed in this document, have been filed. Make sure to check the print media to learn about call dates, or request information from the office of the Board of Examiners of Dentistry. (Calls are ordinarily scheduled between the months of January-February, and July-August of each year.)

**Postal Address:** **PUERTO RICO BOARD OF DENTAL EXAMINERS**  
**P. O. BOX 10200**  
**SAN JUAN, P.R. 00908-0200**

**Telephone:** **(787) 765-2929 Ext. 6605**

**Localization:** **GM GROUP PLAZA BUILDING / Third Floor**  
**#1590 Ponce De León St.**  
**Rio Piedras, Puerto Rico**

**Secretary:** **Cindy L. Reyes**

**Email address:** [\*\*cindy.reyes@salud.pr.gov\*\*](mailto:cindy.reyes@salud.pr.gov)

**To visit our office, please use the information below:**

**For appointments:**

Link: [\*\*https://profesionalesdelasalud.turnospr.com/\*\*](https://profesionalesdelasalud.turnospr.com/)



**To access our portal:**

Link [\*\*https://www.salud.pr.gov/CMS/444\*\*](https://www.salud.pr.gov/CMS/444)



**PRE-DENTAL TRAINING REQUIRED FROM CANDIDATES WHO ASPIRE TO PRACTICE  
THE PROFESSION OF ODONTOLOGY IN PUERTO RICO**

**REQUIREMENTS FOR THOSE WHO GRADUATED FROM REGULAR FOUR (4) YEAR DOCTORAL PROGRAMS**

Spanish.....	12 credits	(1)
English.....	12 credits	(2)
Biology and Zoology.....	8 credits	
Physics.....	8 credits	
Inorganic Chemistry.....	8 credits	
Organic Chemistry.....	8 credits	
Social and Behavioral Sciences.....	6 credits	
Elective Credits.....	28 credits	(3)

**MINIMUM OF CREDITS REQUIRED.....** **90 CREDITS**  
(or a bachelor's in science degree including credits listed above)

**REQUIREMENTS FOR THOSE WHO GRADUATED FROM SPECIAL DOCTORAL PROGRAMS ("ADVANCED PLACEMENT")**

1. Pre-dental training requirements, as listed above.
2. To be in possession of a Doctorate in Dental Surgery or a Doctorate in Dental Medicine under a special advanced placement program, from an educational institution recognized by the Puerto Rico Board of Dental Examiners.

---

- (1) The Spanish-subject requirements may be reduced to 6 credits in the event the candidate has obtained honor ratings in this subject.
- (2) The English-subject requirements may be reduced to 6 credits in the event the candidate has obtained honor ratings in this subject or studied at institutions in the USA.
- (3) Elective credits may be accepted if they are in subjects that can contribute to the comprehensive training of the candidate and to improving his/her knowledge in the field of science.

**CANDIDATES WITH A REDUCTION OF CREDITS IN SPANISH OR ENGLISH ARE NOT EXEMPT FROM COMPLYING WITH THE MINIMUM OF 90 PRE-DENTAL CREDITS REQUIREMENT**

The Board may accept transfer credits for subject matters studied in renowned universities or colleges, if the approval of said credits can be verified against the transcription of credits provided by the institution where the courses were taken and approved with a minimum score.