STATE OF TENNESSEE
DEPARTMENT OF HEALTH
DIVISION OF HEALTH LICENSURE AND REGULATION
OFFICE OF HEALTH RELATED BOARDS
665 MAINSTREAM DRIVE
NASHVILLE, TENNESSEE 37243

TENNESSEE BOARD OF DENTISTRY
(615) 532-3202 or 1-800-778-4123
https://www.tn.gov/health/health-program-areas/health-professional-boards/dentistry-board.html

APPLICATION FOR BOARD APPROVAL OF A CERTIFICATION COURSE IN PROSTHETIC FUNCTIONS

This is an application to request Board approval to conduct a certification course in prosthetic functions. All questions must be answered truthfully by the owner/director of the school applying for approval. The application will be evaluated and, if approved by the Board, an approval letter will be generated for the course. Applications must be received at least 30 days prior to the next regularly scheduled board meeting. Approval of courses will only be effective until December 31st every two years. The rules regulating prosthetic functions and certification courses in prosthetic functions are in 0460-3-.10, 0460-4-.10, 0460-5-.02(4) and 0460-5-.03(6).

Attach a copy of the course syllabus to be utilized in the course to this application for review by the Board.

Contact Information

PLEASE TYPE OR PRINT IN INK (If approved, school name, address and numbers will be posted on Board's website as listed below.)

Name of School/Program: _____

Address: _____

_____

Phone Number: _____

Facsimile Number: _____

E-Mail Address: _____

Name of Owner/Director: _____

Years Approval is requested for: _____
(Approvals are for two years and expire on December 31st every two years)

Has this school/program requested and been granted approval in a previous year? Yes ☐ No ☐

What year(s) was the approval granted? _____

Are there any changes to the curriculum? Yes ☐ No ☐ Are there changes in instructors? Yes ☐ No ☐

Course approval will expire on December 31st every two years.

Facilities and Instructor Information

The Board shall be notified immediately of any changes made in the operation of the certification course, such as change of location, instructors or directorship. **List the location of the course, dates and instructors:**

Name of School where course will be taught: _____

(Must be taught at a school of dentistry or a school which offers a specialty program in a recognized specialty branch of dentistry)

Address: _____

_____

Will all courses be taught at the above location? ☐ Yes ☐ No

If no, list name and address of other school where course will be taught: _____

_____

_____

Date(s) of Course: _____

Name of Instructor(s): _____

_____

_____

_____

Note: All instructors must be Tennessee licensed dentists who are faculty members at an accredited school of dentistry.

Instructor to student ratio for course: _____

Will written and clinical examinations be given? ☐ Yes ☐ No If yes, what is the passing score: _____

Will a comprehensive competency examination be given? ☐Yes ☐ No If yes, what is the passing score: _____

ATTESTATION BY OWNER OR DIRECTOR

I hereby certify that the information provided in this application is accurate and complete. I also certify that the certification course for which Board approval is sought will comply with all statutes and rules regulating admission, facilities, faculty, equipment, and curriculum for certification courses in prosthetic functions.

I understand that, if approved by the Board, the certificate of approval shall expire on December 31st every two years. I understand that failure to adhere to the rules governing the admission qualifications in Rule 0460-3-.10, 0460-4-.10, 0460-5-.02(4)(c)1. and 0460-5-.03(6)(c)1. and the rules for certification courses, including failure to provide access to inspection, pursuant to Rule 0460-5-.02(4)(b) and 0460-5-.03(6)(b), may subject the course to withdrawal of course approval by the Board and invalidation of students course results.

_____ _____

Signature of Owner or Director Date

_____

Name of School