Rhode Island Mission of Mercy
Free Dental Clinic

Rhode Island Oral Health Foundation
1438 Park Avenue
Woonsocket, Rhode Island 02895
rioralhealthfpundation.mom@gmail.com
www.rimom.org

OUT OF STATE PERMIT REQUIRMENT

The purpose of this requirement is to comply with the rules and regulations pertaining to dentists sections 2.5 titled Volunteer Dental/Dental Hygiene Permit. The requirements below are for the Rhode Island Dental Board to issue a volunteer dental/dental hygiene permit to allow an out-of-state dentist/dental hygienist to provide dental or dental hygiene services in Rhode Island without obtaining a Rhode Island license. The request is pursuant to a volunteer dental/dental hygiene permit and shall be limited to the participation in the Mission of Mercy program.

To comply with the requirements, you must complete the following 5 steps at least 14 days prior to the event and mail to:

RI Oral Health Foundation
C/O Dr. Jeffrey Dodge
1438 Park Avenue
Woonsocket, Rhode Island 02895

#1 Print out this PDF

#2 Complete and sign "Non Compensation" form and have it notarized.

#3 Complete all 3 pages of RI Volunteer License Application Form and have it notarized.

#4 Provide a current copy of your dental/dental hygiene license or a letter of good standing from the state where you are currently licensed.

#5 Mail completed forms to Dr. Jeffrey Dodge at address above.

IMPORTANT PLEASE NOTE:

Please be aware that the license issued to you by this application is valid only for the event you are applying for at this time and will be made invalid and unusable upon termination of the event. If you choose to participate in any other event at any other time, you will need to reapply for a new license.

Questions about application?? Contact Dr. Jeffrey Dodge (401) 762-3044

For additional information on volunteer licenses visit www.health.ri.gov

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Applicant Non Compensation Form

_____
Date

_____
Name

_____ _____
Home Address Work Address

_____ _____
City, State, Zip City, State, Zip

_____ _____
Social Security Number Date of Birth

_____
Dental Education

I certify that I will receive no compensation for any dentistry or dental hygiene services from the Rhode Island Oral Health Foundation rendered in Rhode Island while I am in the possession of a volunteer dental permit.

_____
Signature

State of _____

County of _____

On this, the_____ day of _____, 2025, before me a notary public, the undersigned officer, personally appeared _____, known to me (or satisfactorily proven) to be the person whose name is subscribed to the within instrument, and acknowledged that he executed the same for the purposes therein contained.

In witness hereof, I hereunto set my hand and official seal.

_____
Notary Public

FOR OFFICE USE ONLY
Dental Volunteer Checklist

- ☐ Application
- ☐ License Verification
- ☐ Sponsoring Agency Letter
- ☐ Continuing Education Compliance

*****FOR OFFICE USE ONLY*****

ID #

Issue Date

License #

Rhode Island
Board of Examiners in Dentistry

Room 205
3 Capitol Hill
Providence, RI 02908-5097

License #_____

Name_____

Instructions and License Application for:

Volunteer License

☐ Dentist
☐ Dental Hygienist

Applicant - Print Name (First/MI/Last)

Revised 01/30/2013 jcp

State of Rhode Island
Board of Examiners in Dentistry

Refer to the Application Instructions when completing these forms. Type or block print only. Do not use felt-tip pens.

1. Name(s)

This is the name that will be printed on your License/Permit/ Certificate and reported to those who inquire about your License/ Permit/ Certificate. Do not use nicknames, etc.

All questions MUST be answered. Enter "NA" for any question that is NOT APPLICABLE.

First Name

Middle Name

Surname, (Last Name)

Suffix (i.e., Jr., Sr., II, III)

Degree (DMD,DDS)

Maiden, if applicable

Name(s) under which originally licensed in another state, if different from above (First, Middle, Last).

2. Social Security Number

U.S. Social Security Number

"Pursuant to Title 5, Chapter 76, of the Rhode Island General Laws, as amended, I attest that I have filed all applicable tax returns and paid all taxes owed to the State of Rhode Island, and I understand that my Social Security Number (SSN) will be transmitted to the Divison of Taxation to verify that no taxes are owed to the State."

3. Home Address

It is your responsibility to notify the board of all address changes.

1st Line Address (Apartment/Suite/Room Number, etc.)

Second Line Address (Number and Street)

City

State

Zip Code

Country, If NOT U.S.

Postal Code, If NOT U.S.

Home Phone

Home Fax

Email Address (Format for email address is Username@domain e.g. applicant@isp.com)

4. Sponsoring Agency Name and Address

If sponsored by more then one agency, please attach a separate sheet with the required information.

RI ORAL HEALTH FOUNDATION

Name of Business/Work Location

1438 PARK AVENUE

1st Line Address (Department/Suite/Room Number, etc.)

Second Line Address (Number and Street)

WOONSOCKET

City

RI

State

02895

Zip Code

Country, If NOT U.S.

Postal Code, If NOT U.S.

401 762-3044

Business Phone

Extension

401 769-0603

Business Fax

It is your responsibility to notify the board of all locations where you will be providing dental/dental hygiene services. A notarized statement from each sponsoring agency, institution, corporation, association or health care program on a form prescribed by the board, whereby he or she agrees unequivocally not to receive compensation for any dentistry or dental hygiene services he or she may render while in possession of this special license.

5. Current Licensure	I am currently licensed in the practice of dentistry or dental hygiene in the state of [ ][ ] under license number [ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ] and have maintained full licensure in good standing.
6. Affidavit of Applicant Complete this section and sign in the presence of a notary public. Make sure that you and the notary public have completed all components asdfaccurately and completely.	***The foregoing instrument was acknowledged before me this _____ day of _____, 20_____, by_____,*** ***(Applicants Name)*** ***who is personally known to me or has produced _____,*** ***(I.e. license/ID, etc.)*** ***as documentation and did/ did not take an oath.*** _____ Applicant's Signature Notary Seal _____ Notary Public