

INSTRUCTIONS FOR DENTAL HYGIENISTS

There are **two** pathways for licensure in Virginia, **licensure by examination** or **licensure by credentials**. Read through the application instructions carefully before deciding which pathway to pursue. A **completed** application shall include the following unless otherwise stated below. An incomplete application and/or fee will delay the processing of your application. Incomplete applications remain active for one year from the date of receipt. After one year from date of receipt, you would need to reapply for Virginia licensure. Documents submitted with an application are the property of the Board of Dentistry and cannot be returned.

You may view the [status](#) of the checklist items for your application by visiting the Online Applications website, creating an online account, log in with your User ID and Password, and clicking on the "**View Checklist**" link in the Pending Licenses section. Using the View Checklist feature will allow you to review which application items have been completed and which are still outstanding.

1. **Application:** Please be sure that all information and questions are completed on the application.
2. **Application Fee:** The fee for a **dental hygiene license by examination is \$175**, and the fee for a **dental hygiene license by credentials is \$275** and must be paid with a check or money order, made payable to **The Treasurer of Virginia**. The fee can be used for one year from date of receipt. Pursuant to 18VAC60-25-30(F), all fees are non-refundable. Your application will not be reviewed until you have submitted payment.

3. **Official Transcript:** Final **original** transcript bearing SEAL, date degree received (conferred date) and registrar's signature. Copies of transcripts, certificates and diplomas are not acceptable.

(Options: Mail to the Board (address listed above) or the school, e-scrip, or parchment services provider may directly email the transcript information to bodlicensing@dhp.virginia.gov.)

Note: An official transcript –must be on original official school paper (sealed) or an online version that Board staff must download from the school, e-scrip, or parchment services website. **Documentation from foreign countries non-accredited CODA/CDAC schools' programs is not required and will not be considered.**

4. **Form C License Verification: Original** licensure status and certification from every jurisdiction in which you currently hold or have ever held a license/registration/certification to practice as a dentist or as another health care professional. Copies of permits are not accepted. Certifications cannot be older than 6 months from date prepared.

(Options: Mail to the Board (address listed above) or have the issuing state official state representative email the verification directly to bodlicensing@dhp.virginia.gov. If the issuing state/jurisdiction (agency) does not provide an original document, then the applicant must provide/submit the issuing agency statement as to why the issuing agency does not provide verification and submit a copy of the electronic version from the issuing agency website to the Board using either option.)

Documentation from foreign countries is not required and will not be considered.

5. **Clinical Scores:** An **original** (meaning 1 because score cards cannot be combined) detailed score card or report from a Board Approved testing agency documenting passage of a clinical competency examination; meaning a formal test of knowledge and competence in the evaluation, diagnosis, and treatment of dental conditions and the prevention of dental diseases which includes live patient and/or manikin based testing methods to demonstrate the skills needed to safely provide care and treatment of patients, is required.

Candidate's score cards are not acceptable. **All score cards or reports must be requested by the applicant.** (Canadian exams are not accepted.) Certificates are not accepted. (Options: Mail to the Board (address listed on page 1) or have the testing agency official representative email the score report directly to bodlicensing@dhp.virginia.gov, or if applicable, you contact the testing agency and request your test results be made available to the Virginia Board of Dentistry via their online access portal.)

See Guidance Document [60-26](#) Policy On Dental Hygiene Clinical Competency Examination Requirements For Licensure, for both application by examination and credentialing for complete details.

If applying by examination: Applicants who successfully completed a board-approved examination five or more years prior to the date of receipt of their applications for licensure by the Board would be required to provide one of the three documentation options:

1. retake a board-approved examination (original copy of exam scores)
2. take board-approved clinical continuing education as evidence of continuing competence that meets the requirements of 18VAC60-25-190 (copy of completed coursework certificate or transcript)
3. submit documentation that you that you have maintained clinical, unrestricted, and active practice in a jurisdiction of the United States for 48 of the past 60 months immediately prior to submission of an application for licensure. (May use our employment of verification form on page 11 to document employment.)

For example, the five-year period immediately preceding an application received on May 5, 2023, began on May 6, 2018. The five calendar years for this example application are:

First year: May 6, 2018, to May 5, 2019.
Second year: May 6, 2019, to May 5, 2020.
Third year: May 6, 2020, to May 5, 2021.
Fourth year: May 6, 2021, to May 5, 2022.
Fifth year: May 6, 2022, to May 5, 2023, and

Note: It is the applicant's responsibility to prove clinical competency (see guidance document [60-12](#)).

Approval to take a regional examination: Will only be granted to an applicant who is otherwise eligible for an **unrestricted license** as documented in a **completed application**. Approval will not be granted to applicants who do not hold a diploma or certificate from a dental program accredited by CODA or CDAC, as required by §54.1-2709.B(ii) of the Code of Virginia and by 18VAC60-25-130 of the Regulations Governing the Practice of Dental Hygiene. The applicant would need to satisfy all of the unrestricted licensure requirements other than having completed an acceptable clinical exam therefore the applicant would indicate on the application the exam-testing agency you would like to be approved to sit/take a clinical exam.

If applying by credentials: **See the additional requirements in numbers 11 through 13 before selecting this pathway.**

6. **NPDB: Original** current report, not older than 6 months from date prepared, must be obtained by Self Query from the National Practitioner Data Bank (NPDB), which may be requested through their website at www.npdb.hrsa.gov. There is a fee for the report. ***This report from NPDB is required from all applicants, without exception pursuant to Regulation 18VAC60-25-130A(3).***
7. **NBDHE:** An **original** grade card **indicating passage of all parts of the National Board Dental Hygiene Examination** issued by the Joint Commission on National Dental Examinations is required. Copies of grade cards are not accepted. ***(Must be mailed to the Board or you must contact the testing agency to request that your test results be made available to the Virginia Board of Dentistry via online access portal.)***
8. Please be aware that your electronic signature authorizes the release of confidential information, affirms that your application is complete and correct, and attests that you have read, understand, and will remain current with the laws and regulations governing the practice of dentistry in Virginia. Review the laws and regulations via the "Laws and Regulations" tab at <http://www.dhp.virginia.gov/Boards/Dentistry/PractitionerResources/LawsRegulations/>.
9. **Legal/Name Change:** Documentation must be provided to show each name change if your name has ever been changed since graduation from a CODA or CDAC accredited program or were licensed in other jurisdictions **or other than what is listed on your application**. Photocopies of marriage licenses or court orders are accepted.
10. **Address of Record and Publically Disclosable Address:** Consistent with Virginia law §54.1.2400.02 and the mission of the Department of Health Professions, addresses of licensees are made available to the public. Normally, the Address of Record is the publically disclosable address. If you do not want your Address of Record to be made public, state law allows you to provide a second, publically disclosable address. Typically, this other address is the work or practice address. If you would like for your Address of Record to be made available to the public, complete both sections with the same address.

Additional requirements for licensure by credentials which is *the pathway to licensure for an applicant who holds a license in another state, who passed a clinical competency exam referenced for acceptance for licensure by examination in number 5 above, and who has recently practiced dental hygiene for at least for 24 of the past 48 months immediately preceding application for licensure. The applicant is **additionally** required to:*

- _____ 11. **Form B Chronology:** List ALL personal and professional activities, to include all time periods of employment and unemployment, since receiving your doctoral degree or post- doctoral advanced certification. *(Resumes and curriculum vitae are not accepted as substitutes for completing the chronological listing on Form B and will not be considered*

- 12. Hold a **current active dental hygienist license** in another jurisdiction in the United States which was obtained by successfully passing a clinical competency examination comparable to the exam required by the Commonwealth of Virginia.

- _____ 13. Provide verification documentation that you have had “clinical, ethical and legal practice for 24 months out of the previous 48 months immediately preceding application for licensure”. A **notarized statement from each dentist and/or agency** that has employed you within the four years immediately preceding the date of your application (**may use our employment verification form on page 11**). The statement must include the printed name and address of the employer, must include the information required on our employment verification form, and must state the months, days, and years of your employment. Only original, notarized statements are accepted.

For example, the four-year period immediately preceding an application received on May 5, 2023, began on May 6, 2019. The four calendar years for this example application are:

First year: May 6, 2019 to May 5, 2020;
Second year: May 6, 2020 to May 5, 2021;
Third year: May 6, 2021 to May 5, 2022; and
Fourth year: May 6, 2022 to May 5, 2023;

NOTES:

- Completed applications cannot be accessed or edited once they have been submitted.

- If your Virginia License is not issued within 6 months of the date of the NPDB (National Practitioner Databank) Self Query Report and certification of state licensure, then you will be asked to submit a current NPDB Self Query Report and current state licensure certification before your application can be reviewed for approved.

- To receive notice that your supporting documents have been delivered to the Board, it is suggested that the documents be mailed using Fed-Ex or UPS with “Delivery Confirmation”. **Mail sent by USPS is sent to a separate state processing facility that is offsite; therefore, mail can be delayed. Note: if you send something certified by USPS it only verifies that it got to the processing facility and not the Board.**

- The Board does not have reciprocity with any other jurisdiction and cannot grant requests for exceptions to the policies, laws, or regulation nor predetermine acceptance of any documentation prior to the receipt of a complete application.

- Applicant will be notified via email of missing application items within approximately 15 business days from receipt of an application. Once your application is deemed complete, allow 30 business days processing time.

Related contact information:

Clinical Testing Agencies

CDCA (formerly NERB)

The Commission on Dental Competence Assessments
(formerly North East Regional Board)

WREB*

Western Regional Examining Board

CITA

Council of Interstate Testing Agencies

Is now CDCA-WREB-CITA

1304 Concourse Dr, Suite 100
Linthicum, MD 21090
Phone: 301-563-3300
Fax: 301-563-3307

<https://adextesting.org/>

SRTA

4698 Honeygrove Road, Suite 2

Virginia Beach, VA 23455

Phone: 757-318-9082

Fax: 757-318-9085

www.srta.org

CRDTS*

1725 SW Gage Blvd

Topeka, KS 66604

Phone: 785-273-0380

Fax: 785-273-5015

www.crdts.org

*The Board does not accept exams that do compensatory scoring, it is the applicant's responsibility to check with their testing agency about compensatory scoring.

National Board

Joint Commission on National Dental Hygiene Examinations (NBDHE)

211 East Chicago Avenue

Chicago, IL 60611-2678

Phone: 1-800-232-1694

<https://jcnde.ada.org/>

Effective November 30, 2016, the National Board Dental Hygiene Examination (NBDHE) result reports will no longer be sent via mail.

General Information

National Practitioner Data Bank

P.O. P.O. Box 10832

Chantilly, VA 20153

1-800-767-6732

www.npdb.hrsa.gov

Where to Confirm Approved Programs

ADA (American Dental Association)

CODA (Commission on Dental Accreditation)

211 East Chicago Avenue

Chicago, IL 60611-2678

1-800-621-8099 or 312-440-4653

<https://www.ada.org/en/coda>



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9960 Mayland Drive, Suite 300
Henrico, Virginia 23233
(804) 367-4538 (Tel)
(804) 698-4266 (eFax)

bodlicensing@dhp.virginia.gov
<https://www.dhp.virginia.gov/Boards/Dentistry/>

APPLICATION FOR LICENSURE TO PRACTICE DENTAL HYGIENE Page 1

Check the box that applies:

BY EXAMINATION

BY CREDENTIALS

INSTRUCTIONS: Type or print clearly. Complete all sections. If the space provided for any answer is insufficient, complete your answer on a separate page, specify the number of the question to which it relates, sign the page and enclose it with the application.

I. GENERAL INFORMATION: PLEASE COMPLETE ALL SECTIONS (PRINT OR TYPE)

Name: Last*		First	Middle/Maiden	Suffix
Address of record(Mailing Address)		City	State	Zip Code
Publicly Disclosable Address		City	State	Zip Code
Telephone Number				
Email address			Fax #	
Date of Birth		Social Security Number or Virginia DMV control Number**		
____/____/____ Month Day Year		____-____-____ --- --		
Graduation Date		Professional Degree	CODA/CDAC APPROVED DENTAL SCHOOL/CITY/STATE	
____/____/____ Month Day Year				

APPLICANTS DO NOT USE SPACES BELOW THIS LINE – FOR OFFICE USE ONLY

DATE RECEIVED		TRANSCRIPT	NATIONAL BOARD	
NATIONAL PRACTITIONER DATA BANK		CERTIFICATION (LICENSE FROM OTHER STATES (Form C or LETTER)		
SRTA	CDCA-WREB-CITA (CDCA (formerly NERB), WREB & CITA merged in August 2022)	CRDTS	STATE	
CHRONOLOGY (FORM B)		EMPLOYMENT LETTER(S)		

***Name change:** Documentation must be provided to show name change(s) if name has ever been changed from the time you attended school or while you were licensed in other jurisdictions.

****In accordance with § 54.1-116 of the Code of Virginia, you are required to submit your Social Security Number or your control number issued by the Virginia Department of Motor Vehicles. If you fail to do so, the processing of your application will be suspended and fees will not be refunded. This number will be used by the Department of Health Professions for identification and will not be disclosed for other purposes except as provided by law. Federal and state law requires that this number be shared with other agencies for child support enforcement activities.**

FEE AMOUNT	APPLICANT #	LICENSE #	DATE ISSUED

II. EXAMINATIONS –REPORT EVERY EXAM TAKEN ALL QUESTIONS MUST BE ANSWERED

1. Southern Regional Testing Agency (SRTA) – Exam Site _____ /_____/_____
 [] Passed [] Failed [] Never Taken [] Taken more than once (attach explanation) Month/ Day / Year
2. Western Regional Examining Board (WREB) – Exam Site _____ /_____/_____
 [] Passed [] Failed [] Never Taken [] Taken more than once (attach explanation) Month/ Day / Year
3. North East Regional Board (NERB/CDCA) – Exam Site _____ /_____/_____
 [] Passed [] Failed [] Never Taken [] Taken more than once (attach explanation) Month/ Day / Year
4. Central Regional Dental Testing Services, Inc. (CRDTS) –Exam Site _____ /_____/_____
 [] Passed [] Failed [] Never Taken [] Taken more than once (attach explanation) Month/ Day / Year
5. Council of Interstate Testing Agencies, Inc. (CITA) –Exam Site _____ /_____/_____
 [] Passed [] Failed [] Never Taken [] Taken more than once (attach explanation) Month/ Day / Year
6. CDCA-WREB-CITA (ADEX) –Exam Site _____ /_____/_____
 [] Passed [] Failed [] Never Taken [] Taken more than once (attach explanation) Month/ Day / Year
7. State of _____ Exam Site _____ /_____/_____
 [] Passed [] Failed [] Never Taken [] Taken more than once (attach explanation) Month/ Day / Year
8. National Board Examination: (Original grade cards are required) _____ /_____/_____
 [] Passed [] Failed [] Never Taken [] Taken more than once (attach explanation) Month/ Day / Year

9. [] Never Taken a clinical examination (attach explanation)

The Board must receive an original score card or report from the testing agency for each examination reported above. See the Application Instructions #5 and #7 for more details.

III. EXAMINATION APPROVAL: Indicate by checkmark if you need Board approval to take the following exam:

CDCA-WREB-CITA ([ADEX](#)) []

IV. APPLICANT HISTORY: ALL QUESTIONS MUST BE ANSWERED.

If any of the following questions are answered “YES”, explain, and substantiate with documentation. Letters must be submitted by your attorney regarding malpractice suits. Letters must be submitted by any treating professionals regarding health treatment and shall include diagnosis, treatment, and prognosis

1. Are you relocating to Virginia or an adjoining state or the District of Columbia with a spouse who is 1) on federal active-duty orders, or 2) a veteran who has left active-duty service within one year of submission of this application? If “YES”, include a copy of the official military orders with the application. [] Yes [] No

2. Are you active-duty military? If “YES”, include a copy of your official military orders with the application. [] Yes [] No

3. List in chronological order the dental hygiene school(s) attended:

Start Date	Year Completed	Name of Dental Hygiene School	Degree/Certificate Awarded
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

4. List all licenses/registrations/certificates which you have been issued to practice dental hygiene or any other health care professional.

Jurisdiction	Number	Type	Date Issued	Exp. Date
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

LICENSURE TO PRACTICE DENTAL HYGIENE Application Page 3

5. Have you ever been dropped, suspended, expelled, or disciplined by any school or college for any cause whatever? If "YES", give details, schools(s), address(es) and date(s). Please note: the Board may ask for additional documentation. [] Yes [] No

6. Have you ever been denied a license, or the privilege of taking a dental hygiene licensure/competency examination by a licensing authority? If "YES", give details, jurisdiction(s), and date(s) on a separate page. Please note: the Board may ask for additional documentation. [] Yes [] No

7. Have you ever been convicted of a violation or plead Nolo Contendere, to any federal, state, or local statute, regulations, or ordinance, or entered into any plea bargaining relating to a felony or misdemeanor? (Excluding traffic violations, except convictions for driving under the influence.) **Additionally, any information concerning an arrest, charge, or conviction that has been sealed, including arrests, charges, or convictions for possession of marijuana, do not have to be disclosed.** [] Yes [] No

If "YES", give details, jurisdiction(s), and date(s) on a separate page, and include a copy of the disposition/record certified by the Clerk of the Court. Please note: the Board may ask for additional documentation.

8. Have you ever voluntarily surrendered your clinical privileges while under investigation, been censured or warned or been requested to withdraw from the staff of any hospital, nursing home other health care facility, or any health care provider? If "YES", give details, jurisdiction(s), and date(s) on a separate page. Please note: the Board may ask for additional documentation. [] Yes [] No

9. Have you ever had any membership in a professional society revoked, suspended, or sanctioned in any manner? If "YES", give details, jurisdiction(s), and date(s) on a separate page. Please note: the Board may ask for additional documentation. [] Yes [] No

10. Have you ever been a defendant in a military court martial or received medical or other than honorable discharge? If "YES", give details, jurisdiction(s), and date(s) on a separate page. Please note: the Board may ask for additional documentation. [] Yes [] No

11. Have you had any malpractice suits brought against you in the past ten (10) years? [] Yes [] No

If "YES", please provide details for each pending or closed case, list additional claim(s) on a separate page and provide a letter from your attorney explaining each case. Please note: the Board may ask for additional documentation.

Claimant: _____ Date of Incident _____

Name of Defense Attorney: _____

Settlement or Verdict Amount: _____

Name of Involved Insurance Company: _____

Brief description of the claim: _____

Additional Licensure Questions:

1. Do you have any reason to believe that you would pose a risk to the safety or well-being of your patients or clients? If "YES", please provide a full explanation and supporting documentation to the Board. Please note: the Board may ask for additional documentation. [] Yes [] No

2. Are you able to perform the essential functions of a practitioner in your area of practice with or without reasonable accommodation? If "NO", please provide a full explanation and supporting documentation to the Board. Please note: the Board may ask for additional documentation. [] Yes [] No

3. Have you ever been disciplined by any entity? If "YES", please provide a full explanation and supporting documentation to the Board. Please note: the Board may ask for additional documentation. [] Yes [] No

4. Have you ever had any conditions or restrictions been imposed upon you or your practice to avoid disciplinary action by any entity? If "YES", please provide a full explanation and supporting documentation to the Board. Please note: the Board may ask for additional documentation. [] Yes [] No

**VIRGINIA BOARD OF DENTISTRY
APPLICATION AFFIDAVIT**

I hereby certify that I am the person referred to in the forgoing application and the attached supporting documents and that the information on this application and in the attachments is true, complete, and correct to the best of my knowledge.

I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past and present) business and professional associates (past and present) and all governmental agencies and instrumentalities (local, state, federal or foreign) to release to the Virginia Board of Dentistry any information, files or records requested by the Board which is material to me and my application.

I have carefully read the questions in the foregoing application and have answered them completely, without reservations of any kind, I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information on this application, I hereby agree that such act shall constitute cause for the denial, suspension, or revocation of my license to practice dental hygiene in the Commonwealth of Virginia.

I have carefully read the laws and regulations related to the practice of dentistry and dental hygiene. I hereby agree to abide by and remain current with the applicable laws and regulations which are available on <http://www.dhp.virginia.gov/Boards/Dentistry/PractitionerResources/LawsRegulations/>, and

I have attached a check or money order in the amount of \$_____ made payable to the **Treasurer of Virginia**. I fully understand that funds submitted as part of the application shall not be refunded.

Applicant Signature

Date



Virginia Department of
Health Professions
Board of Dentistry

9960 Mayland Drive, Suite 300
Henrico, Virginia 23233
(804) 367-4538 (Tel)
(804) 698-4266 (eFax)

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<https://www.dhp.virginia.gov/Boards/Dentistry/>

**FORM B
CHRONOLOGY**

**ONLY APPLICABLE TO LICENSURE BY CREDENTIALS
(Or LICENSURE BY EXAMINATION IF EXAM WAS COMPLETED OVER 5 YEARS)**

APPLICANT NAME: _____

Every applicant must provide a complete chronological, personal, and professional history of all activities you have engaged in since receiving your degree or certification, including teaching positions, all periods of non-professional activity or employment, volunteer work and all periods of unemployment. **Curriculum vitae and resumes are not accepted as substitutes for completing the chronological listing and will not be considered.**

Form B may be photocopied if copies are needed.

FROM Month/Year	TO Month/Year	Employer/Location of Private Practice, Complete Address, Contact Person & Telephone #	Position Held



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FORM C
CERTIFICATION OF DENTAL HYGIENE BOARDS

Please forward one form to each state dental/dental hygiene board where you hold or have ever held a dental/dental hygiene license. Some states require a fee, paid in advance, for providing this information. To expedite, you may wish to contact the applicable state board(s). Form C may be photocopied if copies are needed.

I am making application for licensure in Virginia by:

- | | | |
|---|---|--|
| <input type="checkbox"/> Examination for Dental License | <input type="checkbox"/> Examination for Dental Hygiene License | <input type="checkbox"/> Dental Restricted Volunteer License |
| <input type="checkbox"/> Credentials for Dental License | <input type="checkbox"/> Credentials for Dental Hygiene License | <input type="checkbox"/> Dental Hygiene Restricted Volunteer License |
| <input type="checkbox"/> Dental Faculty License | <input type="checkbox"/> Dental Hygiene Faculty License | <input type="checkbox"/> Dental Reinstatement |
| <input type="checkbox"/> Dental Temporary Permit | <input type="checkbox"/> Dental Hygiene Temporary Permit | <input type="checkbox"/> Dental Hygiene Reinstatement |

I was granted License Number _____, on _____, _____
Month Date Year by the State of _____.

_____. The Virginia Board of Dentistry requires that I submit evidence of the status of my license. You are hereby authorized to release any information in your files, favorable or otherwise directly to the **Virginia Board of Dentistry** at **9960 Mayland Drive, Suite 300, Henrico, Virginia 23233** or bodlicensing@dhp.virginia.gov. Your early attention is appreciated.

Applicant's Signature

Applicant's Typed/Printed Name

Applicant's Address

Executive Officer of the Board: please send this form directly to the Virginia Board of Dentistry.

State of _____ Name of Licensee _____ License # _____

Graduate of _____ License Type _____ Issued _____

By: Examination* Credentials Reciprocity with the State of _____ Endorsement with the State of _____

*If licensed by a state administered examination, please provide a score card or report which shows that testing included live patients.

License is: Current-Expires _____ Active Inactive Lapsed-Expired _____

Has applicant's license ever been disciplined, suspended or revoked NO YES

If "YES", give details and attach supporting documentation (Finding of Fact, Conclusions of Law, Orders): _____

Comments, if any: _____

SEAL

Signature

Title

Date

Print Name



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<https://www.dhp.virginia.gov/Boards/Dentistry/>

EMPLOYMENT VERIFICATION

(MUST BE COMPLETED BEFORE A NOTARY PUBLIC)

Name of Employing Dentist(s) or Agency: _____

Complete Mailing Address: _____

Telephone Number: _____ Fax Number: _____

Email Address _____

"I, _____ D.D.S./D.M.D./agency representative,
(Print name & Title of the Employing Dentist or Agency Representative)

certify that _____, was employed by me as a _____
(Print Applicant/Employee Name) (Print Job Title)

from ____/____/____ to ____/____/____, in the clinical, ethical, and legal practice of a _____
Month Day Year Month Day Year

_____.

Dentist's/Agency Representative Signature Date

State of _____

County/City of _____

Sworn and subscribed to, before me, this ____ day of _____, ____ Year
Day Month Year

My commission expires on ____
Month Day Year

SEAL/STAMP

Signature of Notary Public

Print Name