

CERTIFICATION OF LICENSURE

The Board of Dentistry will attempt to obtain this information online – If this information is not available online, you will be notified. If required, the completed form must be mailed directly from the state licensing board to the **Idaho State Board of Dentistry**. Any processing fees are the applicant's responsibility. The applicant's signature authorizes release of information, favorable or otherwise, directly to the Board.

Print Name _____ **License #** _____

Signature _____ **Date** _____

This portion of the form should be completed by the state licensing board.

IT IS HEREBY CERTIFIED THAT _____
(Name of Applicant)

WAS GRANTED LICENSE NUMBER _____ **DATE ISSUED** _____

TO PRACTICE _____ **IN THE STATE OF** _____

DATE LICENSE EXPIRES _____ **LICENSE STATUS** _____

BASIS FOR LICENSURE:

- Endorsement/Credentials
- State Board Prepared Written and/or Clinical Exam
- Regional Clinical Exam, Name of Testing Agency _____

YES NO **Disciplinary action ever been initiated, pending, or taken? (If yes, please provide contact information to obtain further information regarding disciplinary action.)**

STATE LICENSING BOARD OFFICIAL:

Print Name _____ **Title** _____

Signature _____ **Date** _____

Phone # _____ **Fax #** _____

Return completed form to:
Email: sbd-info@dopl.idaho.gov

Mail:
IDAHO STATE BOARD OF DENTISTRY
PO Box 83720
Boise, ID 83720-0063
Phone (208) 334-2369

