RESET FORM

BRAD LITTLE
Governor
RUSSELL BARRON
Administrator

State of Idaho
Division Of Occupational and Professional Licenses
Board of Dentistry

11341 W Chinden Blvd.
P.O. Box 83720
Boise, ID 83720-0063
(208) 334-3233
dopl.idaho.gov

I hereby make request for an official verification of license.

REQUESTOR NAME: ____________________

LICENSE NUMBER: ____________________

ADDRESS: ____________________

CITY: ______________ STATE: __________ ZIP: __________

PHONE NUMBER: ____________________

EMAIL: ____________________

Please mail this verification to (if different from above):

NAME: ____________________

ADDRESS: ____________________

CITY: ______________ STATE: __________ ZIP: __________

To email this form, click **HERE**

To print and mail or fax this form, click **HERE**

FOR BOARD USE ONLY:

Date Received: __________

Completed By: __________