Proof of Clinical Practice Affidavit

(This form applies only to applicants for licensure by credentials)

As part of the license by credentials application process, the Idaho State Board of Dentistry requires this form be received from two (2) individuals with direct knowledge of applicant's clinical practice history. These individuals cannot be immediate family members (e.g. spouse, child, parent). The completed form must be mailed directly to the **Idaho State Board of Dentistry.** The applicant's signature authorizes release of information, favorable or otherwise, directly to the Board.

Applicant's Name _____ **Date** _____

Signature _____

****

This portion of the form should be completed by the affiant.

I _____, the undersigned, do of my own personal knowledge make the following statements and declare them to be true.

1. **My profession is** _____

2. **I have known** _____ **from** _____ **to** _____
   Applicant's Name **(MM/YY)** **(MM/YY)**

3. **I have direct and personal knowledge that the applicant has been engaged in the clinical practice of**

   ☐ **Dental Hygiene for a minimum of 1,000 hours in the two years immediately preceding the date as signed below.**

   ☐ **Dentistry for a minimum of three thousand five hundred (3,500) hours in the five years immediately preceding the date as signed below.**

4. **I have this knowledge because:** _____
   _____
   _____
   _____

5. **The following information is the most current and valid for me to be reached for further verification of any information relating to this affidavit.**

   _____
   Address

   _____
   City **State** **Zip**

   _____
   Phone Number **Email Address**

I attest, under penalty of perjury, that my answers and all statements made by me on this affidavit are true and correct. Should I furnish any false information, or cause any material omission, I hereby agree that such act shall constitute cause for denial of the license application for whom this affidavit is intended.

Signature of Affiant _____

Date _____

Return Completed Form by mail or email to:

IDAHO STATE BOARD OF DENTISTRY
PO BOX 83720
BOISE ID 83720-0063
Phone (208) 334-2369

Email: sbd-info@dopl.idaho.gov