

CERTIFICATION OF SPECIALTY TRAINING
(This form applies only to applicants for specialty licensure)

As part of the license application process, the Idaho State Board of Dentistry requires that the school at which the applicant received her/his specialty training complete this form. The completed form must be mailed **directly from the school 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 _____ SSN# _____

Signature _____ Date _____

This portion of the form should be completed by the specialty program.

PLEASE DO NOT COMPLETE THIS CERTIFICATION FORM PRIOR TO THE ACTUAL DATE OF THE STUDENT'S PROGRAM COMPLETION.

IT IS HEREBY CERTIFIED THAT _____
(Name of Applicant)

RECEIVED DENTAL SPECIALTY EDUCATION AT _____
(Name of school)

LOCATED AT _____
(Full Address of School)

FROM _____ TO _____
(Month/Year) (Month/Day/Year)

GRANTED A DEGREE IN THE SPECIALTY FIELD OF _____

DATE DEGREE CONFERRED _____
(Month/Day/Year)

Was the program accredited by the Commission on Dental Accreditation of the American Dental Association at the time the applicant graduated? Yes _____ No _____

President, Dean, Secretary, or Registrar:

Print Name _____ Title _____

Signature _____ Date _____

Phone # _____ Fax # _____

Return Completed Form to:

Idaho Division of Occupational and Professional Licenses
Attn: Idaho Board of Dentistry
11341 W. Chinden Blvd.
Building 4
Boise, ID 83714

Email: HP-Licensing@dopl.idaho.gov
Phone (208) 334-3233

