FLORIDA DEPARTMENT OF HEALTH DIVISION OF MEDICAL QUALITY ASSURANCE BOARD OF DENTISTRY	APPLICATION FOR DENTAL AND DENTAL HYGIENE LAWS & RULES RE-EXAMINATION ONLY

1. APPLICATION CATEGORY

_____ DENTAL _____DENTAL HYGIENE

2. APPLICANT PROFILE DATA–

- Please attach check or money order
- Please print or type or application will be returned

Name:	Last First Middle	Home Telephone: Area Code ( )	Business Telephone: Area Code ( )
Mailing Address	Street and No. Apt. No. City State Zip	Place of Birth: (City, State, Country)	
Practice Location	Street and No. Apt. No. City State Zip	Have you ever changed your name through marriage or through action of a court, or have you ever been known by any other name? Yes No If yes, list name(s) and date(s) of change(s) below:	

Height Weight Eye Color Hair Color U.S. Citizen Yes No

E-mail address:

3. SPECIAL TESTING ACCOMODATIONS

Please indicate if you require special testing accommodations due to disability, or if you have a religious conflict with the scheduled examination date. If yes, contact Testing Services immediately at (850) 245-4252 for detailed information and application. All requests must be in writing and include supporting documents.

☐ Yes ☐ No

Mail this application with fee to:
Department of Health
Post Office Box 6330
Tallahassee, FL 32314-6330
www.floridasdentistry.gov

Contact us at (850) 245-4474 or info@floridasdentistry.gov