Application for Dental Credentials Review for Graduates from Non-Accredited Dental Colleges or Schools

Board of Dentistry
P.O. Box 6330
Tallahassee, FL 32314-6330
Website: www.floridasdentistry.gov
Email: info@floridasdentistry.gov
Phone: (850) 245-4474
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Florida HEALTH
Medical Quality Assurance

Application for Dental Credentials Review for Graduates from Non-Accredited Dental Colleges or Schools

Board of Dentistry
4052 Bald Cypress Way, Bin C-04
Tallahassee, FL 32399-3258
Fax: (850) 921-5389
Email: info@floridasdentistry.gov

Dental Credentials Review (701) **No Fee**

1. PERSONAL INFORMATION

Name: _____ **Date of Birth:** _____
Last/Surname First Middle MM/DD/YYYY

Mailing Address: (The address where mail and your license should be sent)

_____ _____ _____
Street/P.O. Box Apt. No. City

_____ _____ _____
State ZIP Country

_____ _____
Home/Cell Telephone (Input without dashes) Work/Business Telephone (Input without dashes)

EQUAL OPPORTUNITY DATA:

We are required to ask that you furnish the following information as part of your voluntary compliance with 41 CFR Part 60-3-Uniform Guidelines on Employee Selection Procedure (1978); 43 FR 38295 and 38296 (August 25, 1978). This information is gathered for statistical and reporting purposes only and does not in any way affect your candidacy for licensure.

Gender: ☐ Male ☐ Female

Race: ☐ Native Hawaiian or Pacific Islander ☐ American Indian or Alaska Native ☐ Two or More Races ☐ Hispanic or Latino ☐ Black or African American ☐ White ☐ Asian

Email Notification: To be notified of the status of your application by email, check the "Yes" box and fill in your email address on the line provided. If you choose to be notified via email you will be responsible for checking your email regularly and updating your email address with the board office.

☐ Yes ☐ No Email Address: _____

Under Florida law, email addresses are public records. If you do not want your email address released in response to a public records request, do not provide an email address or send electronic mail to our office. Instead contact the office by phone or in writing.

Name: _____

2. EDUCATION HISTORY

List dental school(s) attended.

School Name	Address	Graduation Date (MM/DD/YYYY)	Degree Awarded

List supplemental dental education program(s) completed.

Program Name	Address	Completion Date (MM/DD/YYYY)

3. ADDITIONAL REQUIREMENTS

Provide the following documentation:

- ☐ **A General Evaluation Report** completed by Educational Credentials Evaluators Inc. (ECE)
- ☐ **Proof of completion of a supplemental general dentistry program** accredited by the Commission on Dental Accreditation, in accordance with section 466.006(3)(b), Florida Statutes
- ☐ **Proof of successful completion of the National Board Dental Examination**, sent **directly** to the board office from the American Dental Association

Documentation should be sent to the board office at:

Board *of* Dentistry
4052 Bald Cypress Way Bin C-04
Tallahassee, FL 32399-3258

4. APPLICANT AFFIRMATION

I understand that this review is solely for the purpose of approval to sit for the ADEX dental licensing examination and does not guarantee licensure as a dentist in the state of Florida or any other state.

Applicant Signature _____ Date _____
You may print this application and sign it or sign digitally. MM/DD/YYYY