

Application for Dental Hygiene 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
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Phone: (850) 245-4474
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Application for Dental Hygiene 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 Hygiene Credentials Review (702)

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

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

3. ADDITIONAL REQUIREMENTS

Provide the following documentation:

A Subject Analysis Evaluation Report completed by Educational Credentials Evaluators Inc. (ECE)

Proof of completion of dental degree in accordance with section 466.007(3), Florida Statutes and Rule 64B5-2.0144, Florida Administrative Code (transcripts and **copies** of dental diploma; all documents must be translated to English). Do not send your original diploma. Our office does not maintain original documents and they **will not** be returned by mail.

Proof of successful completion of the National Board Dental Examination, sent **directly** to the board office from the American Dental Association

Submit documentation to the board office at:

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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