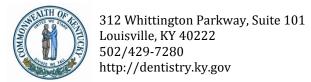
Date received

Kentucky Board of Dentistry



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ADVISORY OPINION REQUEST FORM

than one individual is submitting this request):

Name				
Address				
City			State	ZIP
Phone number	Fax number	Email		
submitted on be	half of a corporation	on or associatio	on, please include:	
Name of Entity			Phone number	Fax number
Address				
City			State	ZIP
he date of publica		he opinion bel	d advisory opinion, pow and include the ed letter.	
Date of publication	Topic of opin	ion		

This advisory opinion request is submitted by (please attach an additional page if more

Return this form attached to your request for an advisory opinion to the Kentucky Board of Dentistry at the address above.