

Date	Juris.	CPR	Verification	NPDB	Backgrnd
Fee	Boards	Clinical	Transcript	License No.	Issue Date

FOR KBD USE ONLY

Form AFDL0525  
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# Kentucky Board of Dentistry

312 Whittington Parkway, Ste. 101, Louisville, KY 40222

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## APPLICATION FOR DENTAL LICENSURE

Return this complete application, supporting documents, and payment (check or money order made out to the Board of Dentistry) to the address above. Application fees are \$325 if applying in an even-numbered year or \$175 if an odd year. Add \$25 for the NPDB fee if you have previously held a dental license in any jurisdiction. If necessary, attach an additional sheet to fully answer all questions.

Name: Last/Suffix \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_

Former Name(s) \_\_\_\_\_ SS# \_\_\_\_\_ Gender (M/F) \_\_\_\_\_

Citizen of \_\_\_\_\_ If naturalized U.S. citizen, give date and place \_\_\_\_\_

Date of Birth \_\_\_\_\_ Place of Birth \_\_\_\_\_ Preferred Mailing Address \_\_\_\_\_ Home \_\_\_\_\_ Business \_\_\_\_\_

Home Address, City, State, Zip \_\_\_\_\_

Home/CellPhone \_\_\_\_\_ Email \_\_\_\_\_

Intended Business Address (if known) \_\_\_\_\_

Business Name \_\_\_\_\_ Business Phone \_\_\_\_\_

Applying for \_\_\_\_\_ Licensure by Exam \_\_\_\_\_ Licensure by Credentials \_\_\_\_\_ Licensure by Foreign Training \_\_\_\_\_ Student Limited License \_\_\_\_\_ Faculty Limited License \_\_\_\_\_

Clinical Exam Completed \_\_\_\_\_ Date \_\_\_\_\_ Location \_\_\_\_\_

Identify the successful completion of all CODA accredited graduate or postgraduate programs below. Documentation of program completion should accompany this application.

*School/Program*

*Location*

*Degree*

*Dates Attended*

\_\_\_\_\_

\_\_\_\_\_

Identify all states or other licensing jurisdictions where you have held or currently hold a dental license.

*State*

*License #*

*State*

*License #*

\_\_\_\_\_

\_\_\_\_\_

Identify all places of practice since graduation, beginning with the most recent.

*Business Name & Address*

*Dates*

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please affirm all TRUE statements below and attach a written explanation for any FALSE statements:

- |   |      |       |
|---|------|-------|
| 1. I am a graduate of a CODA accredited DMD/DDS program or post-graduate general dentistry program?             | True | False |
| 2. I understand, read, speak, and write English with a least a ninth grade (Level 4) comprehension.             | True | False |
| 3. I have successfully completed the National Board written exam.   | True | False |
| 4. I have successfully completed a qualifying clinical exam within three attempts.                              | True | False |
| 5. I have never had a dental license or DEA permit denied, revoked, restricted or disciplined.                  | True | False |
| 6. I have never been suspended, sanctioned, or restricted from a private or public insurance program.           | True | False |
| 7. I have have not surrendered or failed to renew a dental license while under investigation.                   | True | False |
| 8. I do not have disciplinary action pending against my dental license, DEA permit, or insurance participation. | True | False |
| 9. I have never been convicted of a misdemeanor or felony.  | True | False |
| 10. I have not been sued for malpractice, negligence, or professional misconduct.                               | True | False |

**Notarized affidavit to be signed in the presence of a notary**

I, the undersigned, hereby certify under penalty of law that I am the person referred to in this application, that the attached photograph is of myself, and that the information provided herein is accurate and complete to the best of my knowledge. I authorize the Kentucky Board of Dentistry or its agents to obtain from other sources any information necessary to confirm my qualifications. I understand that the submission of false or fraudulent information as part of this application is grounds for disciplinary and/or legal action. I further attest that I understand and agree to abide by the statutes and regulations governing dentistry in Kentucky as codified in KRS 313 and 201 KAR 8.

*Attach a head and shoulders  
photograph taken within the  
past six months.*

*No hats, please.*

Applicant Signature \_\_\_\_\_ Date \_\_\_\_\_

\_\_\_\_\_ For Use by Notary Public \_\_\_\_\_

State of \_\_\_\_\_ County of \_\_\_\_\_

Signed and sworn before me this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_

Signature \_\_\_\_\_ Commission Expires \_\_\_\_\_

Notary Seal