



# Kentucky Board of Dentistry

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## STATEMENT REGARDING FACULTY LICENSURE LIMITATIONS

In accordance with [201 KAR 8:533](#), I understand that upon receipt of a Faculty Limited License issued by the Board of Dentistry, I will be authorized to practice dentistry only in conjunction with programs of the dental school where I am a faculty member and that I may only provide professional services to patients of these programs.

I further acknowledge that I am solely responsible for the requirements of maintaining and renewing my Faculty Limited License as required by law.

Name \_\_\_\_\_ University \_\_\_\_\_

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