Dental Laboratory Registration

Instruction Sheet

1. Complete application
2. Submit $150 application fee
3. Submit copy of CDT card or certificate
4. Mail to:

   Kentucky Board of Dentistry
   312 Whittington Parkway, Suite 101
   Louisville, KY 40222
APPLICATION FOR REGISTRATION OF DENTAL LABORATORIES

Please print in ink or type your responses.

Laboratory Name

Laboratory address ____________________________
Number & Street (PO Boxes Not Acceptable)

City ______________________________ State __________ ZIP __________ KY County __________ Phone # ____________________

Email address ____________________________________________ Call phone number ____________________

Certified Dental Technician Name ____________________________ CDT number __________________________
(Assign copy of Current CDT card or certificate to application)

OR

Supervising Dentist Name ____________________________ License # __________

This laboratory meets the infectious disease control requirements under Occupational Safety and Health Administration (OSHA) and the Centers for Disease Control and Prevention (CDC) of the United States Public Health Service. 

☐ ☐ YES NO

As the supervising CDT/Dentist, I acknowledge that this laboratory will provide material disclosure to the prescribing dentist that contains the U.S. Food and Drug Administration registration number of all patient contact materials contained in the prescribed restoration in order that the dentist may include such numbers in the patient’s record.

Certified Dental Technician/Dentist Signature ____________________________ Date ______________

As the supervising CDT/Dentist, I acknowledge that this laboratory will disclose to the prescribing dentist the point of origin of the manufacture of the prescribed restoration. If the restoration was partially or entirely manufactured by a third-party provider, the point of origin disclosure shall identify the portion manufactured by a third-party provider and the city, state, and country of such provider.

Certified Dental Technician/Dentist Signature ____________________________ Date ______________