

FOR KBD USE ONLY



Kentucky Board of Dentistry

312 Whittington Parkway, Ste. 101, Louisville, KY 40222
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APPLICATION TO REINSTATE DENTAL OR DENTAL HYGIENE LICENSURE

Please print in ink or type your responses, using your name as it appears on your dental license. Return this notarized application, supporting documents, and application fee (check or money order made out to Kentucky Board of Dentistry) to the address above. The dentist fee is \$325 if applying in an even numbered year or \$175 if an odd numbered year. For hygienists, the fee is \$75 (even year) and \$125 (odd year).

Name: Last/Suffix _____ First _____ Middle _____

Former Name _____ Date of Birth _____ SS # _____

Former License # _____ Home/Cell Phone _____ Business Phone _____

Email _____ Applying for reinstatement of: Dentist License Dental Hygienist License

Preferred Mailing Address: Home Business Intended Business Name _____

Business Address _____

Home Address _____

States (include license #) practiced in since licensed in KY _____

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

- | | | |
|--|------|-------|
| 1. I have actively practiced dentistry/dental hygiene within the last two years. | True | False |
| 2. I have never had my license or prescribing authority denied, revoked, restricted or disciplined. | True | False |
| 3. I have have not surrendered or failed to renew a dentist/hygienist license while under investigation. | True | False |
| 4. I have not ever been convicted of a misdemeanor or felony. | True | False |
| 5. I have not been sued for malpractice, professional negligence, or insurance code violations. | 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, rules, and regulations governing dentistry in Kentucky.



Applicant Signature _____ Date _____

_____ For Use by Notary Public _____

State of _____ County of _____

Signed and sworn before me this _____ day of _____,

Notary Seal

Signature _____ Commission Expires _____