Kentucky Board of Dentistry

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RETIREMENT OF LICENSE FORM

Please print in ink or type your responses, using your name as it appears on your license. Use the contact information above to mail, fax, or email this form. Once received and processed, the Board shall send confirmation of license retirement.

Name: Last/Suffix ______________________________ First ______________________________ Middle ______________________________

Home Address ____

Home/Cell Phone ______________________________ Email ____

License Type: Dentist Dental Hygienist License # ____________________ Effective Date of Retirement _______ / _______ / _______

I, the undersigned, hereby certify under penalty of law that I am the person referred to in this form and that the information provided herein is accurate and complete to the best of my knowledge. I agree not practice in Kentucky after the effective date listed above. I understand that my license shall not be properly retired if there is pending disciplinary action against it. Further, I acknowledge that if I intend to reinstate my license in the future, I must meet the requirements as set forth in Kentucky's statutes and regulations.

Signature ____ Date ____________________