Approved by

FOR KBD USE ONLY

Kentucky Board of Dentistry

312 Whittington Parkway, Ste. 101
Louisville, KY 40222
502-429-7280
502-429-7282 fax
kbd@ky.gov

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, the Board shall send written confirmation of retirement to the address below.

Section 1. Licensee Information

Name: Last/Suffix ___________________________________ First _____________________________ Middle _________________

Address ____ City _____________________________________

State ________ Zip ____________ Phone _________________________ Email ____

License # _______________ License Type __________________________ Effective Date of Retirement ______ / ______ / ______

Section 2. Signed Affidavit

I hereby submit to the Kentucky Board of Dentistry official notice of my intent to retire my license. I certify the above facts to be true and, under penalty of law, 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. Furthermore, 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 _________________