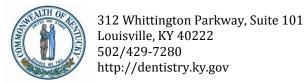
Approved by

Kentucky Board of Dentistry



FOR KBD USE ONLY

STATEMENT REGARDING FACULTY LICENSURE LIMITATIONS

I understand that upon receipt of a faculty limited license issued by the Kentucky Board of Dentistry, I am authorized to practice dentistry only in conjuction 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 all of the requirements for renewal of my faculty limited license as set out in statute and regulation.

| Signed: | |
|---------------------|--|
| | |
| Name of University: | |
| | |
| Current date: | |