Approved by

FOR KBD USE ONLY

Kentucky Board of Dentistry

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502/429-7280
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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: _____