# Dental Laboratory Registration

## Instruction Sheet

1. **Complete application**
2. **Submit $150 application fee**
3. **Submit copy of CDT card or certificate**
4. **Mail to:**

Kentucky Board of Dentistry
312 Whittington Parkway, Suite 101
Louisville, KY 40222

| Fee | Date |
|---|---|
| Registration Number | |
| Approved By | |
| Date of Issue | |

**FOR KBD USE ONLY**

Rev. June 2014

# Kentucky Board of Dentistry

312 Whittington Parkway, Suite 101
Louisville, KY 40222
502/429-7280
http://dentistry.ky.gov

## APPLICATION FOR REGISTRATION OF DENTAL LABORATORIES

Please print in ink or type your responses.

Laboratory Name _____

Laboratory address _____
Number & Street (PO Boxes Not Acceptable)

_____
City State ZIP KY County Phone #

Email address _____ Cell phone number _____

Certified Dental Technician Name _____ CDT number _____
(Attach copy of Current CDT card or certificate to application)

**OR**

Supervising Dentist Name _____ License # _____

*This laboratory meets the infectious disease control requirements under Occupational Safety and Health Administration (OSHA) and the Centers for Disease Control and Prevention (CDC) of the United States Public Health Service.*

☐ YES ☐ NO

*As the supervising CDT/Dentist, I acknowledge that this laboratory will provide material disclosure to the prescribing dentist that contains the U.S. Food and Drug Administration registration number of all patient contact materials contained in the prescribed restoration in order that the dentist may include such numbers in the patient's record.*

Certified Dental Technician/Dentist Signature _____ Date _____

*As the supervising CDT/Dentist, I acknowledge that this laboratory will disclose to the prescribing dentist the point of origin of the manufacture of the prescribed restoration. If the restoration was partially or entirely manufactured by a third-party provider, the point of origin disclosure shall identify the portion manufactured by a third-party provider and the city, state, and country of such provider.*

Certified Dental Technician/Dentist Signature _____ Date _____