



DENTAL BOARD OF CALIFORNIA

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CERTIFICATION OF THE CLINICAL PRACTICE OF DENTISTRY

If you were employed at multiple locations during a time period documented below, submit one form per location.

This form shall certify that the person named below has been employed in active clinical practice or has been a full-time faculty member and in active clinical practice. This information is intended for use in establishing eligibility for licensure in California through the Licensure by Credential pathway.

I certify that the applicant, _____, has been in
(Print full name of applicant)

- Active clinical practice, or
- A full-time faculty member and in active clinical practice at an accredited dental education program(s)

in the State of _____ during the dates below:

From (M/D/Y)	To (M/D/Y)	Hours per Year	Total Hours Combined
Are you self-employed? <i>(Does not apply for full-time faculty member)</i>			<input type="checkbox"/> YES <input type="checkbox"/> NO
Are you a full-time faculty member and in active clinical practice? <i>(If you selected yes, please have your dental education program send a letter certifying such.)</i>			<input type="checkbox"/> YES <input type="checkbox"/> NO
Business name or name of education program and address, during the period indicated above (include city/state/zip): if different from the practice address.			
Practice address: if different from the business address.			

I certify under penalty of perjury that I am custodian of records of the business listed above, and that the above statements are true and correct.

Name of Person Certifying

Signature of Person Certifying

Date of Signing

Telephone Number

Email Address