



**OUT-OF-STATE/COUNTRY LICENSE CERTIFICATION**  
**LBC APPLICANTS ONLY**

INSTRUCTIONS TO APPLICANT: Complete top portion of form. Submit to any State or Country in which you have been licensed regardless of the status of license. Completed forms should be submitted with your application.

(Please type or print neatly)

1. Name	_____	_____	_____
	Last	First	Middle
2. Address	_____	_____	_____
	City	State	Zip Code
3. Birthdate	_____	4. Sex	_____
	MM/DD/YYYY	<input type="checkbox"/> Female <input type="checkbox"/> Male	Licensing Agency

**TO BE COMPLETED BY LICENSING AGENCY:**

I certify that \_\_\_\_\_ , who graduated from  
Name of Applicant  
\_\_\_\_\_ on \_\_\_\_\_ , was granted  
Name of Dental School                      Date of Graduation  
license number \_\_\_\_\_ on \_\_\_\_\_ , in the  
Date License Issued  
State/country of \_\_\_\_\_ , on the basis of \_\_\_\_\_  
State/Country                      RECIPROCITY, NATIONAL BOARD EXAM,  
LICENSING AGENCY EXAM  
and the license expires on \_\_\_\_\_ .  
MM/DD/YYYY

I certify that such license is currently in good standing; and that no disciplinary action is pending or has been taken against the license.

NOTE: if any portion of the above certification is deleted or modified, please attach explanation.

_____	_____
Type or Print Name and Title of Agency Official	Name of Licensing Agency
_____	_____
Signature of Agency Official	Street Address
<b>[SEAL]</b>	_____
_____	City State Zip
_____	_____
DATE	Telephone Number