



Request for Certification of California Dental License

Non-Refundable Fee: \$50.00
Enclose personal check or money order

For Office Use Only	
Amount	_____
Receipt	_____
File #	_____
Received Date	_____

Name (first, middle, last) _____
Telephone Number _____ License Number _____
Address to which you wish the certificate sent:

DECLARATION: *I authorize the Dental Board of California to send a certification of my California dental license to the address above.*
Signature _____ Date _____

<u>Complete this section only if exam score is required.</u>	
DECLARATION <i>I authorize the Dental Board of California to disclose the scores from my California dental license examination to the address above within 60 days of the date of my signature.</i>	
Signature	_____ Date _____

<p align="center">INFORMATION COLLECTION AND ACCESS</p> <p>The information requested herein is mandatory and is maintained by Dental Board of California, 2005 Evergreen Street, Suite 1550, Sacramento, CA 95815, Executive Officer, 916-263-2300, in accordance with Business & Professions Code, §1600 et seq. Failure to provide all or any part of the requested information will result in the rejection of the request as incomplete. Each individual has the right to review the personal information maintained by the agency unless the records are exempt from disclosure.</p>
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