ARKANSAS STATE BOARD OF DENTAL EXAMINERS
101 EAST CAPITOL AVENUE, SUITE 111
LITTLE ROCK, AR 72201
PHONE: 501-682-2085 FAX: 501-682-3543

VERIFICATION OF LICENSURE REQUEST

Applicant: Please complete the top portion of this form and send it to every state dental board where you have been licensed (whether license is current or not).

Name: ____

Complete Address: ____
Street or P.O. Box *City* *State* *Zip*

Home Phone: ____________________ Business Phone: ____________________

State: __________ Type of license: ☐ Dental license ☐ Hygiene license License number: __________

State Dental Board: The applicant named above has applied for a license to practice dentistry or dental hygiene in the State of Arkansas. The Arkansas State Board of Dental Examiners is requesting license verification and information on this individual. Please complete this form and mail it directly to the Arkansas State Board of Dental Examiners.

LICENSEE: *(Full name as it appears on license)*	
PROFESSION: *(Dentistry or Dental Hygiene)*	
SPECIALTY:	
LICENSE NUMBER:	
DATE LICENSED:	
HOW WAS APPLICANT LICENSED?	☐ Examination *Which exam(s)?* ____________________ ☐ Reciprocity *From which state(s)?* ____________________ ☐ Credentials *Requirements:*
LICENSE EXPIRATION DATE:	
STATUS OF LICENSE: *(Active or Inactive)*	
HAS LICENSE EVER BEEN PUT ON PROBATION, SUSPENDED OR REVOKED?	☐ Yes *(If yes, please explain or provide a copy of Order.)* ☐ No
IS THERE ANY DISCIPLINARY ACTION PENDING?	☐ Yes *(If yes, please explain.)* ☐ No

____
Board Administrator

(SEAL)

____
Full name of licensing board

____
Date