STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS

STATE AND CONSUMER SERVICES AGENCY • GOVERNOR EDMUND G. BROWN JR.
Dental Board of California
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DENTAL ASSISTING PROGRAM
LICENSE CERTIFICATION FORM

$25.00 FEE REQUIRED
For each request

For Office Use Only:
Cashiering No.: _____
Prepared by: _____
Date Mailed: _____

Please type or print clearly in ink.

License Type: ☐ RDA ☐ RDAEF ☐ DSA ☐ OA **License No:** _____

Full Name: _____
Address: _____
City, State, Zip: _____
Home Phone: _____ **Work Phone:** _____

Is the above an address change? ☐Yes ☐No If yes, please provide your previous address below:
Previous Address: _____

Address you wish the Certification to be sent:

Name: _____
Address: _____
City, State, Zip: _____

DECLARATION: I authorize the Dental Board of California to send a certification of my California license to the address above.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

This declaration is executed on the _____day of _____ 20_____.

Signature: _____

Please allow 30 days for processing.