



## Request for Certification of California Dental License

**Non-Refundable Fee: \$2.00**  
Enclose personal check or money order

### For Office Use Only

Receipt \_\_\_\_\_ RC \_\_\_\_\_  
Date \_\_\_\_\_ \$ \_\_\_\_\_  
Mailed 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 \_\_\_\_\_

**Complete this section only if exam score is required.**

**DECLARATION** *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.*  
Signature \_\_\_\_\_ Date \_\_\_\_\_

**INFORMATION COLLECTION AND ACCESS** 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.