



X-ray License Replacement Request

Non-Refundable Fee (must accompany application.)

\$50 for dentists (16 CCR § 1021(k))

Reason for Request

Lost Destroyed Stolen Original Not Received
 Other, specify _____

For Office Use Only

Receipt _____ RC _____

Date Filed _____ \$ _____

Approved _____ Denied _____

RP# _____

Name (first, middle, last) _____ Telephone _____

Name license issued under (if different than above) _____

Full address _____

Dental License number _____ X-ray License number, if known _____

Month, day, year original X-ray license was issued _____

Name of issuing agency _____

certify under penalty of perjury under the laws of the State of California that the statement(s) and information set forth above are correct, that I will immediately return the license to the Dental Board should said license be found, or report its whereabouts should it become known to me.

Signature _____ Date _____

INFORMATION COLLECTION AND ACCESS

The information requested herein is mandatory and is maintained by Dental Board of California, 1432 Howe Ave, Suite 85, Sacramento, CA 95825, Executive Officer Cynthia Gatlin, 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.