ARKANSAS STATE BOARD OF DENTAL EXAMINERS
101 East Capitol Avenue, Suite 111
Little Rock, Arkansas 72201
Phone: 501-682-2085
Web: healthy.arkansas.gov Email: asbde@arkansas.gov

For Board Use Only:
Lic. #_____

DOL: _____

Spec: _____

Application for Dental Specialty License

Please type using Adobe Acrobat or a similar program.
Handwritten applications will not be accepted.

**In addition to this application and fee, please enclose a copy of your specialty certification.*

First Name Middle Name Maiden Name Last Name Degree

Address: (Street or PO Box) City State Zip

Social Security Number Home Phone # Business Phone #

Email Address Arkansas Dental License Number

Source of Specialty Training: _____ Dates: _____

In which specialty are you seeking licensure? _____

In addition to the foregoing:

1. I hereby give my permission for the Arkansas State Board of Dental Examiners to secure information concerning me or any statements in this application, or any other information supplied by me, from any person or any source the Board may desire.

2. I further agree to submit to questioning by the Board or any duly appointed representative of the Board, and to substantiate my statements if it is desired.

3. I have attached a check or money order in the amount of **$15.00** to cover this application fee. I understand that this fee will be returned only if the Arkansas State Board of Dental Examiners does not accept this application.

4. I solemnly declare upon my honor that if granted a license to practice a dental specialty in Arkansas, I will respectfully comply with the laws governing the practice of Dentistry in the State and the standing rules governing the practice of a specialty as approved by the Arkansas State Board of Dental Examiners, and will do my best to uphold and maintain the ethics of the profession.

_____ _____

Signature of Applicant Date