**Nevada State Board of Dental Examiners**
6010 S. Rainbow Blvd., Bldg. A, Ste. 1
Las Vegas, NV 89118
(702) 486-7044 • (800) DDS-EXAM • Fax (702) 486-7046

# APPLICATION FOR SPECIALTY CERTIFICATION

***Note: This application must be submitted at least forty-five (45) days prior to a regular Board Meeting.***

In accordance with and subject to the rules and regulations governing the Nevada State Board of Dental Examiners, I hereby make application for issuance of a certificate in the dental specialty area of:

_____
(Name of Specialty)

Full Name: _____

Office Address: _____

Residence Address: _____

Mailing Address: _____

Telephone office: _____ Telephone Residence: _____

**Formal dental specialty training was completed in:** _____
(Area of Specialty)

**At:** _____
(Name of Institution)

**Located in:** _____
(City and State)

**From:** _____ **To:** _____
(Month and Year) (Month and Year)

**I served under the following chief(s) of service during the period(s) of specialty training:**

Name: _____ Title: _____

Address: _____ Telephone: _____

Name: _____ Title: _____

Address: _____ Telephone: _____



*Revised 09/2013*

# AFFIDAVIT AND PLEDGE

**STATE OF** _____

**COUNTY OF** _____

The person named as the applicant in the foregoing application, being first duly sworn, deposes and says: I am the applicant for certification referred to; I have carefully read the questions in the foregoing application and have answered them truthfully, fully and completely without mental reservation of any kind. I further understand I have a continuing obligation to inform the Board should any of my answers since filing this application change prior to the Board issuing me a certificate. In the event I fail to update the answers which have changed since submitting this application, I understand that such failure is grounds for revocation of any certification issued or denial of the application.

I hereby authorize educational and other institutions, my references (past and present), business and professional associates (past and present), insurance carriers, professional societies, and all governmental agencies and instrumentalities (local, state, federal or foreign) to release to the Nevada State Board of Dental Examiners any information, files, or records requested by the Board in connection with the processing of this application. I further authorized the Nevada State Board of Dental Examiners to release to the organizations, individuals and groups listed above any information furnished by me or received by the Board and material to my application.

I hereby pledge myself to the highest standards and ethics in the practice of my specialty, and upon my honor do hereby declare that I will confine my practice exclusively to this specialty. A violation of this pledge may be deemed sufficient cause for the revocation of a certificate issued by the Board.

It is understood and agreed that the title of all certificates shall remain in the Nevada State Board of Dental Examiners and shall be surrendered by order of said Board.

I UNDERSTAND THAT ANY OMISSIONS, INACCURACIES OR MISREPRESENTATION OF INFORMATION ARE GROUNDS FOR DISAPPROVAL AND REJECTION OF THIS APPLICATION AND THE REVOCATION OF A CERTIFICATE WHICH MAY HAVE BEEN OBTAINED THROUGH IT.

**Signature of Affiant** _____

(Notary seal)

**Date** _____

**Signature of Notary** _____

***<u>The following information and documentation must be received by the Board office prior to consideration of specialty certification:</u>***

1. ***Completed, signed and notarized application form. All questions must be answered in full;***
2. ***Non-refundable application fee in the amount of $125;***
3. ***Copy of certificate of completion of specialty training from a program accredited by the American Dental Association Commission on Accreditation;***
4. ***Certification of Specialty Program Completion form, sent directly to the Board office from the educational institution where specialty training was completed;***
5. ***Current National Practitioners Data Bank Report (cannot be more than 90 days old at time of receipt of specialty application);***

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# Certification of Specialty Program Completion

This is to certify that _____ (*Name of Student/License Applicant)* attended the _____ *program (Name of Specialty Program)* at _____ (*Name of Accredited Educational Institution*) for the period of _____ to _____. He/She successfully completed the program on _____ and was awarded specialty certification in the area of _____ *(Name of Specialty).*

*OFFICIAL SEAL OF ACCREDITED EDUCATIONAL INSTITUTION (If Available)*

_____
(Original Signature of Dean. *No stamped signatures)*

_____
Printed Name of Dean Date