



ARKANSAS STATE BOARD OF DENTAL EXAMINERS

4815 W. Markham Street, Slot 79

Little Rock, Arkansas 72205

Phone: 501-682-2085

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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:

- 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.
- 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.
- 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.
- 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