Credential Verification Request
American Board of General Dentistry-Board Certified

Date: ___________

Requesting Facility: _______________________________________

Address:____

City: ______________________ State: _______ Zip: __________

Contact Person: _______________________________________

Telephone: (______)______________________Ext: _________

Email: *(required)* ______________________________________

List names to be verified **Last Name, First Name, Middle Initial**	**Signed Release Attached Please Circle**	**ABGD Use Only**
	Yes/No	
	Yes/No	
	Yes/No	
	Yes/No	

Please enclose $15.00 per verification, per individual. *# of verifications:* _________

☐ Check #: ___________ ☐ Charge: Please circle one: Visa Mastercard

Name of Facility issuing Check or Charge: ____

Name as it appears on card: ___________________________ Exp Date: __________________

Credit Card Billing address: ____

City: ___________________________________ State: _________ Zip:_____________

Credit Card #: _______________________________________ 3 Digit Code: _________

I authorize the charge of $ ___________. I affirm that the information I have provided in this form is correct and I authorize the American Board of General Dentistry to proceed with the above credit card charge.

Date: ________________

Print Name: ______________________________ Sign Name: _____________________________

Fax Request Form, and Signed Release(s) to: 727-586-3331

OR Mail Check with request & signed release to:

American Board of General Dentistry
PO Box 7613
Seminole, FL 33775-7613

Phone: 561-809-5491 E-mail: support@ABGD.org

NOTE: Verifications can not be released over the phone, fax or e-mail.