Please type or print:   Ref. #: ___________________

Name: ________________________________________________________

LAST    FIRST    MI

Address: ______________________________________________________

Number and Street  Apt #

City    State    Zip

Telephone: Home (      )____________________________Work (      )_______________________________________

Fax Number: (      )______________________________Cell Number: (     )___________________________________

E-Mail (required): ________________________________________________________________________________

Dental School: ____________________________________________  Year of Graduation: _____________________

Date of Birth:_____________ Year in which you became Educationally Qualified for Certification: _____________

EXAMINATION - LOCATION/DATE: Please check the appropriate box and fill in the blanks

❏ Tampa, FL:  March/April  Year: ________________

❏ AGD Annual Meeting:  Location: __________________________
                       June/July Year: ________________

Military Facility Test Site

❏ March/April  Location:__________________________ Year: ________________

❏ June/July  Location:__________________________ Year: ________________

TCO Verification Letter Included:   ❏ Yes   ❏ No

Please note that all candidates testing at their assigned military facility must submit a letter to the ABGD office from their Commanding Officer (CO), on Command letterhead, verifying that the CO will accept receipt of the examination and assign a Testing Control Officer (TCO) to administer, maintain security, and return the completed exam to the ABGD according to the rules and procedures included in the examination packet. Upon receipt, the ABGD office will fax an "Exam Administrator Agreement" to be signed by both the CO and TCO and returned to the ABGD. The Commanding Officer and TCO will be the points of contact for any inquiry regarding the status of the written board examination. Commanding Officers must include in the letter their office phone number, fax number, email address of both the CO and TCO, and a shipping address for receipt of the testing materials. Copying of exam books or test questions is strictly prohibited and is a violation of policies established by the ABGD. CANDIDATES WILL NOT BE PERMITTED TO TEST WITHOUT THE COMMANDING OFFICER'S LETTER AND BOTH THE CO/TCO'S EXAM ADMINISTRATOR AGREEMENT ON FILE

Special Accommodations

The American Board of General Dentistry (ABGD) will grant special accommodations for the Written and Oral Examinations to a candidate who:

1) submits a letter, a minimum of 60 days before the examination deadline, requesting special accommodations, and
2) provides documentation verifying his/her condition as well as the specifics of the special accommodations from a qualified professional (physician, psychologist, counselor) currently treating the candidate.

The ABGD reserves the right to authorize the use of auxiliary aids or modifications in such a way as to maintain the integrity and security of the examination process.
Exam Fees - Please check the appropriate box
Note: This application cannot be processed unless the candidate has been deemed “Educationally Qualified.”

☐ $400 - Exam Fee

ABGD Study Guide

The ABGD Study Guide contains 100 sample study questions which reflect the content make-up of the exam. Included is an answer key and an answer sheet so candidates can simulate testing and score their own results.

☐ $45 Study Guide

Payment Method - Please check the appropriate box

☐ Check - payable to ABGD (in U.S. dollars Only)  3 digit verification code __________ (required)

☐ Credit Card:  ☐ Visa  ☐ MasterCard  Total $___________________

Credit Card Billing Information (Information must match your card statement address)
Name as it appears on card: _______________________________ Exp Date: ________________
Credit Card Billing address: __________________________________________ State: _______ Zip: ________
City: ___________________________________________ 3 Digit Code: __________
Credit Card #: __________________________________________
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: _____________________

I, the undersigned, certify the above information is correct. I understand that the application fee is NON-REFUNDABLE.

I have read the Rules and Procedures and agree to abide by the regulations therein.

____________________________________________  _______________________
SIGNATURE         DATE

MAIL THE COMPLETED FORM ALONG WITH THE PROPER PAYMENT TO:

THE AMERICAN BOARD OF GENERAL DENTISTRY
490 Indian Rocks Rd. Suite A
Belleair Bluffs, FL 33770-2085

QUESTIONS??
Please call:
561-809-5491
or
email: AssistantABGD@Tampabay.rr.com