AMERICAN BOARD OF GENERAL DENTISTRY
QUALIFYING APPLICATION

Please type or print clearly:

Name: _____
First **Middle** **Last**

Please give both home and office addresses below.

Preferred Address: ❑ **Home** ❑ **Office**

_____

_____

_____
City **State/Province** **Zip Code**

Phone: ( ) _____ **Fax:** ( ) _____

Cell: ( ) _____ **Email (required)** _____

Secondary Address: ❑ **Home** ❑ **Office**

_____

_____

_____
City **State/Province** **Zip Code**

Phone: ( ) _____ **Fax:** ( ) _____

Email (required): _____

Education: _____
Dental School **Degree** **Year Graduated**

Have you ever been found guilty of an offense which caused, or might have caused, your dental license to be revoked? ❑**Yes** ❑**No**

If "yes," please explain circumstances on a separate sheet of paper.

Go on to the next page

Have you ever had your license to practice dentistry restricted or revoked? ❑Yes ❑No

If "yes," please explain circumstances on a separate sheet of paper.

I hereby apply to The American Board of General Dentistry for the issuance of a certificate indicating that I am credentialed in the practice of general dentistry upon successfully meeting all the requirements relative thereto, all in accordance with and subject to its constitution, bylaws, and rules and regulations in force at this time. I agree to disqualification from examination or from issuance of a certificate in the event that any of the statements hereinafter made by me are false or in the event that I violate any of the rules governing such examination. I agree that said American Board of General Dentistry its members, officers, examiners, and/or agents shall not be liable for any action any or all of them may take in good faith in connection with this application, any investigation made or examination held there under, the grade given with respect to the examinations, or for failure of said organization to issue me such certificate.

Signature: _____ Date: _____

I affirm that the information I have provided in this Qualifying Application is accurate. I understand that The American Board of General Dentistry may check the accuracy of the course credits listed, as well as that of credits awarded for any other dentally-related activities. I agree to abide by the decision of The American Board of General Dentistry regarding my educational qualifications for certification.

Signature: _____ Date: _____

Exam Fees - Please check the appropriate box

❑$300 - Qualifying Application Fee

Payment Method

❑Check - payable to ABGD (in U.S. dollars only)

❑Credit Card: ❑Visa ❑MasterCard _____

3-digit verification code *(Required)*

Total $ _____

_____

Credit Card # Expiration Date Name as it appears on card

_____

Signature (cannot process credit card without signature)

Special Accommodations

The American Board of General Dentistry (ABGD) may 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.

THE AMERICAN BOARD OF GENERAL DENTISTRY
QUALIFYING APPLICATION
ENTRY POINT I

ENTRY POINT I: 2-year GPR/AEGD

Location of GPR/AEGD: _____

School, Hospital, Institution or Service

_____

_____

_____

_____

Address

Director's Name: _____

Years you attended program: _____

Date program completed: _____

ATTACH A PHOTOCOPY OF YOUR GPR/AEGD CERTIFICATE OF COMPLETION