



Dental Board of California



Application for Issuance of License Number and Registration of Place of Practice*

Business & Professions Code §§ 1650

OFFICE USE ONLY
Date Application Received

OFFICE USE ONLY
ATS #
Rec #
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Date cashiered
Date License mailed
License #

Complete this form to obtain your license. Please print legibly.

Name Last First Middle

Address of Record (will be public information)

Street and Number

City State Zip Code

Address of Practice, if different
Street and Number

City State ZIP Code

*Note: If you do not yet have a practice address in California, you may leave this section blank. However, if and when you do have a practice address in California, you must report it to the Board immediately.

Telephone number () Email address (optional)

Applicant's File Number issued by Dental Board of California

Certification

I certify under penalty of perjury under the laws of the State of California that the information I provided to the Board in this application is true and correct.

Date

Signature of Applicant

The information requested herein is mandatory unless designated as optional and is maintained by Dental Board of California, 2005 Evergreen Street, Suite 1550, Sacramento, CA 95815, Executive Officer, 916-263-2300, in accordance with Business & Professions Code, §1600 et seq.

The information requested will be used to determine eligibility. Failure to provide all or any part of the requested information will result in the rejection of the application as incomplete. Each individual has the right to review the personal information maintained by the agency unless the records are exempt from disclosure. Applicants are advised that the names(s) and address(es) submitted may, under limited circumstances, be made public.