

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF STATE
BUREAU OF PROFESSIONAL AND OCCUPATIONAL AFFAIRS
STATE BOARD OF DENTISTRY
P.O. BOX 2649
HARRISBURG, PA 17105-2649

Telephone: 717-783-7162

Facsimile: 717-787-7769

Website: www.dos.pa.gov/dent

Email: st-dentistry@pa.gov

INSTRUCTIONS FOR POST-GRADUATE TRAINING NOTIFICATION

1. NOTIFICATION MUST BE SUBMITTED PRIOR TO ENTERING A POST-GRADUATE PROGRAM. POST-GRADUATE TRAINING MAY NOT BEGIN PRIOR TO RECEIVING AUTHORIZATION FROM THE BOARD. AUTHORIZATION WILL NOT BE GRANTED UNTIL THE APPLICATION IS COMPLETE.
2. APPLICANT MUST SUBMIT A \$75.00 CHECK OR MONEY ORDER PAYABLE TO THE "COMMONWEALTH OF PA". DO NOT SEND CASH. FEES ARE NON-REFUNDABLE. NOTE: A \$20.00 PROCESSING FEE WILL BE ASSESSED FOR ANY PAYMENT RETURNED BY YOUR BANK, REGARDLESS OF THE REASON FOR NON-PAYMENT.
3. THE APPLICANT MUST COMPLETE PAGE 1 OF THE APPLICATION IN ITS ENTIRETY, SIGN, DATE AND SUBMIT THE COMPLETED FORM TO THE BOARD OFFICE.
4. THE SUPERVISING DENTIST AT THE CODA ACCREDITED TRAINING PROGRAM MUST COMPLETE PAGE 2 OF THE APPLICATION IN ITS ENTIRETY, SIGN, DATE AND SUBMIT THE COMPLETED FORM TO THE BOARD OFFICE.
5. THE DENTAL SCHOOL WHERE YOU OBTAINED YOUR DDS/DMD DEGREE MUST COMPLETE THE CERTIFICATION OF GRADUATION FORM. THE FORM MUST BE SIGNED BY THE PROPER OFFICIAL OF THE SCHOOL, CONTAIN THE SEAL OF THE DENTAL SCHOOL AND BE SENT DIRECTLY FROM THE SCHOOL IN A SEALED OFFICIAL SCHOOL ENVELOPE. (PAGE 3 MAY NOT BE COMPLETED OR SUBMITTED PRIOR TO GRADUATION. PHOTOCOPIES, FAX COPIES AND ELECTRONIC SUBMISSIONS ARE NOT ACCEPTED.)

GRADUATES OF UNACCREDITED DENTAL SCHOOLS ONLY: IN ADDITION TO THE ABOVE-REQUIRED DOCUMENTATION FROM YOUR SCHOOL, YOU MUST ALSO PRESENT YOUR CREDENTIALS TO AN APPROVED EDUCATION CERTIFICATION AGENCY FOR EVALUATION. THE EDUCATION CREDENTIAL EVALUATION AGENCY MUST FORWARD AN OFFICIAL EVALUATION REPORT OF YOUR EDUCATION WHICH REFLECTS THAT THE EDUCATION YOU HAVE COMPLETED THROUGH THE UNACCREDITED DENTAL SCHOOL IS EQUIVALENT TO THE U.S. DMD/DDS DEGREE. THE EVALUATION REPORT MUST BE SUBMITTED DIRECTLY FROM THE EVALUATING AGENCY IN A SEALED OFFICIAL ENVELOPE.

NOTE:

1. IF AN INDIVIDUAL HOLDS A CURRENT LICENSE TO PRACTICE DENTISTRY IN PENNSYLVANIA, THIS APPLICATION IS NOT REQUIRED.
2. THE DENTAL LAW ALLOWS FOR "THE PRACTICE OF DENTISTRY IN A DENTAL CLINIC OPERATED NOT FOR PROFIT FOR THE DURATION OF AN INTERSHIP, RESIDENCY OR OTHER GRADUATE TRAINING PROGRAM APPROVED BY THE AMERICAN DENTAL ASSOCIATION COMMISSION ON DENTAL ACCREDITATION OR A DENTAL ANESTHESIOLOGY TRAINING PROGRAM THAT MEETS THE STANDARDS OF AN ACCREDITING BODY ACCEPTABLE TO THE BOARD, BY PERSONS HAVING ACQUIRED THE PRELIMINARY AND PROFESSIONAL EDUCATION REQUIRED FOR ADMISSION INTO THE PROGRAM, AFTER NOTIFICATION TO THE BOARD".
3. PLEASE ALLOW AT LEAST 2-4 WEEKS FOR PROCESSING OF YOUR APPLICATION. INCOMPLETE APPLICATIONS WILL CAUSE DELAY IN THE ISSUANCE OF YOUR AUTHORIZATION. ALL CORRESPONDENCE AND THE AUTHORIZATION WILL BE SENT DIRECTLY TO THE RESIDENCY PROGRAM.
4. SHOULD THE APPLICATION NOT BE COMPLETED WITHIN SIX MONTHS, UPDATED DOCUMENTATION MAY BE REQUIRED. ADDITIONALLY, IF THE APPLICATION PROCESS HAS NOT BEEN COMPLETED WITHIN ONE YEAR FROM THE DATE IT WAS RECEIVED, APPLICANTS WILL BE REQUIRED TO SUBMIT AN UPDATED APPLICATION-PROCESSING FEE.

Mailing Address:

STATE BOARD OF DENTISTRY
 P.O. BOX 2649
 HARRISBURG, PA 17105-2649



Tel: 717-783-7162 Fax: 717-787-7769

E-Mail: st-dentistry@pa.gov

Website: www.dos.pa.gov/dent

Courier Delivery Address:

STATE BOARD OF DENTISTRY
 2601 NORTH THIRD STREET
 HARRISBURG, PA 17110

APPLICATION FOR POST-GRADUATE TRAINING NOTIFICATION

APPLICANT INFORMATION													
NAME:	<table style="width: 100%; border: none;"> <tr> <td style="border: none; width: 33%;">_____</td> <td style="border: none; width: 33%;">_____</td> <td style="border: none; width: 33%;">_____</td> </tr> <tr> <td style="border: none; text-align: center;">LAST</td> <td style="border: none; text-align: center;">FIRST</td> <td style="border: none; text-align: center;">MIDDLE</td> </tr> </table>	_____	_____	_____	LAST	FIRST	MIDDLE						
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LAST	FIRST	MIDDLE											
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STREET													

CITY	STATE	ZIP CODE											
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(_____)	_____	_____											
Email address: _____													
Name of the Dental School From Which You Graduated:	Year of Graduation:												
_____	_____												
Have you completed any prior dental internship/residency training program(s)? Yes <input type="checkbox"/> or No <input type="checkbox"/>													
If yes, list the name(s), location(s) and date(s) of completed training below: _____ _____													
The post-graduate training authorization for which you are applying must occur through a CODA accredited program. List the name of the dental school/hospital where the training will occur: _____													
If any document required for licensure is in a name other than above , please indicate the name(s). A copy of the appropriate name change document must be attached. _____													
VERIFICATION STATEMENT													
By signing below, I verify that this form is in the original format as supplied by the Department of State and has not been altered or otherwise modified in any way. I am aware of the criminal penalties for tampering with public records or information pursuant to 18 Pa. C.S.§4911.													
Additionally, I certify that the statements in this application are true and correct to the best of my knowledge, information and belief, and that I am of good moral character. I understand that any false statement made is subject to the penalties of 18 Pa. C.S.§4904 relating to unsworn falsification to authorities and may result in the suspension, revocation or denial of my license, certificate, permit or registration.													
Signature of Applicant: _____	Date: _____												

