Complete forms and supporting documents must be mailed to:

Board of Dentistry
4052 Bald Cypress Way Bin C-04
Tallahassee, FL 32399-3258

Board of Dentistry Individual Study Application

(Instructors, Teachers, and Lecturers)

Please **type** all responses. If questions are not applicable, enter N/A in the field. The applicant statement must be signed for this application to be accepted. Complete and submit a separate application for each sponsoring institution/organization.

1. PERSONAL INFORMATION

Name: _____ License #: _____
Last/Surname First Middle

Mailing Address: _____
Street/P.O. Box City

State: _____ ZIP: _____ Telephone: _____

2. TEACHERS, INSTRUCTORS, AND LECTURERS

Title or Position: _____

Sponsoring Organization/Institution: _____

3. LECTURES PRESENTED

Course Title	Date (MM/DD/YYYY)

4. CLINICAL TEACHING

Course Title	Date (MM/DD/YYYY)

5. VALIDATION (Director of sponsoring organization must sign)

Total Lecture Hours: _____

Director Name and Title: _____

Director Signature: _____ Date: _____
MM/DD/YYYY

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6. APPLICANT STATEMENT

A copy of this statement will be returned to you after the Board of Dentistry has reviewed and approved your application. The applicant must sign the statement for this application to be accepted.

I hereby certify that the answers on this application are true and correct.

Applicant Signature: _____ Date: _____
MM/DD/YYYY

You are required to keep your own records for four years, including this affidavit.

FOR FLORIDA BOARD OF DENTISTRY USE ONLY

Subject Matter: _____

Date Received: _____
MM/DD/YYYY

Date Approved: _____
MM/DD/YYYY

Approved by: _____

Date Approved Pending: _____
MM/DD/YYYY

Sections Needing Clarification: _____

Deadline for Submitting Clarification: _____
MM/DD/YYYY

Date Denied: _____
MM/DD/YYYY

Number of Hours Awarded: _____