## Complete forms and supporting documents must be mailed to:

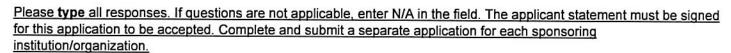
**Board of Dentistry** 

4052 Bald Cypress Way Bin C-04

Tallahassee, FL 32399-3258

## **Board of Dentistry Individual Study Application**

(Instructors, Teachers, and Lecturers)



Name:  Last/Surname First Middle  Mailing Address:	City	cense #:
	City	
Mailing Address:		
mailing / taarcoo.		
Street/P.O. Box		
State: ZIP: Telephone:		
2. TEACHERS, INSTRUCTORS, AND LECTURERS		
Title or Position:		
Sponsoring Organization/Institution:		
3. LECTURES PRESENTED		
<u>Course Title</u>		Date (MM/DD/YYYY)
		-
<u>-</u>		-
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
Board of Dentistry Individual Study Application	
(Instructors, Teachers, and Lecturers)	
C ADDITIONAL CTATEMENT	
6. APPLICANT STATEMENT	
A copy of this statement will be returned to you after the Board of Dentistry has	s 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:	5.
Applicant Signature.	Date: MM/DD/YYYY
	55/
You are required to keep your own records for four years	s, including this affidavit.
FOR ELORIDA ROARD DE DENTISTRY HI	SE ONLY
FOR FLORIDA BOARD OF DENTISTRY US	SE ONL Y
Subject Matter:	
Date Received:	
MM/DD/YYYY	
Date Approved:	
MM/DD/YYYY	
Approved by:	
Арріочео ву	
Date Approved Pending:	
MM/DD/YYYY	
Sections Needing Clarification:	
Deadline for Submitting Clarification:	
MM/DD/YYYY	
Date Denied: MM/DD/YYYY	
INIMINUTAL T	
Number of Hours Awarded:	