

**MISSISSIPPI STATE BOARD OF DENTAL EXAMINERS
REQUEST FOR LICENSURE APPLICATION PACKET**

CANDIDATE NAME: _____

CANDIDATE ADDRESS: _____

CANDIDATE TELEPHONE: _____

CANDIDATE E-MAIL: _____

NAME OF SCHOOL: _____

DATE OF GRADUATION: _____

PACKET REQUESTED:

- | | |
|--|---|
| <input type="checkbox"/> DENTAL BY CREDENTIALS | <input type="checkbox"/> HYGIENE BY EXAMINATION |
| <input type="checkbox"/> DENTAL BY EXAMINATION | <input type="checkbox"/> HYGIENE BY CREDENTIALS |
| <input type="checkbox"/> DENTAL PROVISIONAL | <input type="checkbox"/> HYGIENE PROVISIONAL |
| <input type="checkbox"/> DENTAL PROVISIONAL FELLOWSHIP | <input type="checkbox"/> HYGIENE PROVISIONAL FELLOWSHIP |
| <input type="checkbox"/> DENTAL PROVISIONAL TEACHING | <input type="checkbox"/> HYGIENE PROVISIONAL TEACHING |

This form has been designed by Adobe Acrobat Professional 8, and candidates may use the reader version of Adobe Acrobat to complete the form. Once this form has been completed, please print it and attach a personal check, money order, or certified check in the amount of \$10.00 made payable to the Mississippi State Board of Dental Examiners. The form should be returned to the Mississippi State Board of Dental Examiners at the following address:

**Mississippi State Board of Dental Examiners
Suite 100, 600 East Amite Street
Jackson, MS 39201-2801**

Please contact the Board at 601-944-9622 or dental@msbde.state.ms.us if you have any questions.

HANDLING FEE FOR NON-SUFFICIENT FUND CHECKS ARE \$50.00

Print Form

TO BE COMPLETED BY MSBDE OFFICE:

Date Request Received: _____ Date Packet Mailed: _____

Processing Fee of \$10.00 Received

Money Order

Certified Check