DENTAL APPLICATION FOR LICENSURE
CANDIDATE ADDRESS AND LICENSE INFORMATION
FOR THE MISSISSIPPI STATE BOARD
OF DENTAL EXAMINERS

MSBDE Rev. 03/10/2009

Please **TYPE** the information requested below as you would have it appear on your license.

FIRST NAME MIDDLE NAME LAST NAME

The full name will be the permanent name in which the candidate's license will be issued and will **NEVER** be changed, regardless of marital status.

CITY, STATE, & COUNTRY OF BIRTH DATE OF BIRTH

PLACE OF RESIDENCE (STREET, CITY, STATE, ZIP CODE)

HOME TELEPHONE NUMBER SOCIAL SECURITY NUMBER

DENTAL SCHOOL ATTENDED DATE OF GRADUATION

ADDRESS TO WHICH LICENSE SHOULD BE MAILED (If you are a current graduate and unsure of an address for the months of May or June, please have your license sent to a permanent address, such as parents, grandparents, etc.)

E-MAIL ADDRESS

This form MUST be included with the candidate's Application for Licensure by Examination or Credentials to Practice Dentistry.

Print Form