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:

- ☐ DENTAL BY CREDENTIALS
- ☐ DENTAL BY EXAMINATION
- ☐ DENTAL PROVISIONAL
- ☐ DENTAL PROVISIONAL FELLOWSHIP
- ☐ DENTAL PROVISIONAL TEACHING
- ☐ HYGIENE BY EXAMINATION
- ☐ HYGIENE BY CREDENTIALS
- ☐ HYGIENE PROVISIONAL
- ☐ HYGIENE PROVISIONAL FELLOWSHIP
- ☐ 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.

Print Form

TO BE COMPLETED BY MSBDE OFFICE:

Date Request Received: _____ Date Packet Mailed: _____

☐ Processing Fee of $10.00 Received

☐ Personal Check ☐ Money Order ☐ Certified Check ☐ Cash