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

Revised 03/19/2019

Print Form

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.		