If applying via Residency, the following form must be completed.

CERTIFICATE OF DIRECTOR OF DENTAL RESIDENCY PROGRAM

ATTESTATION

I am the Director of _____.
(Residency Program)

This is a _____ year dental residency program accredited or approved by the Commission
(# of years)
on Dental Accreditation and is administered by an accredited dental college or hospital,

specifically _____.
(Name of Dental College or Hospital)

As Director of the aforementioned dental residency program, I attest that

_____ began the program on _____ date and has satisfactorily
(Name of Applicant) **(Start Date)**
completed the program on _____ date, and has demonstrated a level of competency in
(End Date)
dentistry which in my opinion qualifies _____ for a license to
(Name of Applicant)
practice dentistry in the state of Ohio.

Program Director:

_____
Printed Name

_____
Signature Date

Notary:

Signed and sworn before me this _____ day of _____ , 20___ .

Signature of Notary Public: _____

Expiration Date of Commission: _____

(Notary Seal)