



Ohio State Dental Board
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Dental.Ohio.Gov

CERTIFICATE OF APPOINTMENT AS A RESIDENT

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This certifies that is enrolled in a Residency or Fellowship
Applicant's full name **(Circle One)**

in the program at
Program Type **Dental College/ Program of a Hospital**

that has been **approved or accredited by the CODA and AGGME**. The term of this appointment starts on

and ends on .
mm/dd/yyyy **mm/dd/yyyy**

Program Director Signature Date
Program Director **Signature**

Chief of Dental Services Signature Date
Signature of Chairman (if applicable)

Institution Address
Phone Number
Email Address