A FEE OF $20.00 MUST ACCOMPANY THIS APPLICATION

OHIO STATE DENTAL BOARD
77 SOUTH HIGH STREET, 17TH FLOOR
COLUMBUS, OHIO 43215-6135

APPLICATION FOR DUPLICATE LICENSE

THE FOLLOWING INFORMATION MUST BE FURNISHED UNDER OATH:

NAME YOU WISH PRINTED ON YOUR CERTIFICATE:_____

I HEREBY MAKE APPLICATION FOR A DUPLICATE LICENSE TO PRACTICE DENTISTRY/DENTAL HYGIENE/DENTAL ASSISTANT RADIOGRAPHY IN THE STATE OF OHIO.

SAID ORIGINAL LICENSE WAS ISSUED TO ME ON THE _____DAY OF_____, IN THE YEAR _____, BEING NUMBER _____ AND WAS ISSUED IN THE NAME OF _____.

I DESIRE A DUPLICATE LICENSE FOR THE FOLLOWING REASON:

☐ **1. ORIGINAL LICENSE WAS LOST OR DAMAGED.**

☐ **2. WISH DUPLICATE LICENSE FOR DISPLAY IN SECOND OFFICE.**

☐ **3. CHANGE OF NAME (A COPY OF THE COURT ORDER OR MARRIAGE LICENSE IS REQUIRED.)**

I WISH TO PRACTICE DENTISTRY UNDER SUCH DUPLICATE LICENSE AT:

_____

STREET ADDRESS CITY STATE ZIP CODE

(DENTAL HYGIENISTS/DENTAL ASSISTANT RADIOGRAPHERS LIST HOME ADDRESS BELOW)

_____

STREET ADDRESS CITY STATE ZIP CODE

AFFIDAVIT

STATE OF _____)
COUNTY OF _____)
BEING DULY SWORN, SAYS THAT HE/SHE IS THE PERSON REFERRED TO IN THE APPLICATION AND THAT THE STATEMENTS CONTAINED HEREIN ARE TRUE IN EVERY RESPECT.

S E A L

_____
SIGNATURE OF APPLICANT

SUBSCRIBED AND SWORN TO BEFORE ME THIS _____DAY OF_____, 19____.

MY COMMISSION EXPIRES _____WITNESS MY HAND AND SEAL HEREUNTO ATTACHED.

_____
SIGNATURE OF NOTARY PUBLIC