Oregon Health Licensing Agency

700 Summer St. NE, Suite 320
Salem, OR 97301-1287
(503) 378-8667
TTY: (503) 373-2114
Fax: (503) 370-9004
Web Site: http://www.oregon.gov/OHLA
E-Mail: ohla.info@state.or.us

Board of Denture Technology

APPLICATION FOR DENTURIST INTERN SUPERVISOR

COMPLETE ALL PARTS OF THIS FORM. PLEASE TYPE OR PRINT IN INK. Call the Health Licensing Agency if you have any questions. If this application is not complete it will be returned. Use "N/A" to indicate information that is not applicable.

Name First	Middle	Last
Date of Birth (month/date/year)	❑ Male ❑ Female	Social Security #
Mailing Address	Street Address or P.O. Box	
City	State	Zip Code
Message Phone ( )		Fax Number ( )
Home Telephone ( )		Business Telephone ( )

PLEASE CHECK ALL THAT APPLY

❑ Application for becoming a supervisor in the State of Oregon is being made prior to beginning direct supervision and training of any individual.

❑ I hold a valid license and have been in active practice for three years prior to the date of this application.
❑ Dentist ❑ Denturist

License #__________ Date Issued: ____/____/____ Expiration Date:____/____/____ State__________

❑ I operate an on-site laboratory and clinic where the direct supervision and training will occur. If not, indicate where training will occur:
❑ Laboratory ❑ Clinic

❑ I will not supervise more than two (2) persons at a given time.

❑ Denturists ***ONLY***: I hold an oral pathology indorsement.

I have examined this application and attached documents, and certify that they are true, correct and complete. I will comply with the laws and rules adopted by the Board pursuant to ORS 680 and OAR 331-420-0000.

Signature of Applicant **Date**

For Official Use Only

Issued: __________ Entered: ____/____/____/ ________(Initials)

Years of Practice:________ Oral Path: ❑ Yes ❑ No # of current interns: