CERTIFICATE OF LICENSURE

(Not applicable if no state licenses have been obtained)

Name of Applicant (Please Print or Type)		
Street Address		
City	State	Zip Code:
License No:	Date Issued:	

I certify that _____ was granted license number _____ to practice _____ in the State of _____, on the basis of successfully passing _____ examination.

STATUS OF LICENSE
- ☐ Current — Expiration Date _____
- ☐ Expired — Date _____
- ☐ Inactive — Expiration Date _____
- ☐ Revoked — Date _____

Type of License Issued
- ☐ Full
- ☐ Limited
- ☐ Conditional/Restricted (Please explain)

Legal/Disciplinary Action: ☐ Yes ☐ No

Legal/Disciplinary Action Pending ☐ Yes ☐ No ☐ Unable to disclose

If yes, please attach copies of any disciplinary/legal action or pending disciplinary/legal action.

_____
Signature of Official

SEAL

_____
Title

_____
Date Certificate Prepared

Return directly to:

Oregon Board of Dentistry
1500 SW 1st Avenue, Suite 770
Portland, Oregon 97201