



THE STATE BOARD OF DENTAL EXAMINERS
333 GUADALUPE TOWER 3 STE 800
AUSTIN TX 78701
512.463.6400 OR (fax) 512.463.7452

REQUEST FOR REGIONAL EXAMINING BOARD APPROVAL

First Name	Middle Name	Maiden Name	Last Name
Social Security Number	Date of Birth	Place of Birth	

MAILING ADDRESS

Street	Apt #	City	State	Zip
Home Telephone _____	Business Telephone _____			

DENTAL EDUCATION

Dental Degree (attach copy of diploma)	School Location	Year of Graduation
Specialty Training Program (attach copy of program completion certificate)	School Location	Date of Completion

I am applying to register (please check one) for the:

Western Regional Examining Board Central Regional Dental Testing Service

Based on my dental education and subsequent specialty training, I have met the qualifications of the Dental Practice Act to pursue dental licensure in Texas. Attached are copies of my dental diploma and specialty program completion certificate. Please send approval for the indicated Regional Examining Board so that I may register for their clinical examination.

Signature

Date