VERIFICATION OF LICENSE - DENTIST

Access this form via website at: **hawaii.gov/dcca/pvl**

Board of Dental Examiners
State of Hawaii
Department of Commerce and Consumer Affairs
PVL Licensing Branch
P.O. Box 3469
Honolulu, HI 96801

APPLICANT: Complete Applicant section and mail to all jurisdictions where you hold or held a license at anytime. Contact the appropriate licensing agency for information on their processing time and service fees.

APPLICANT

Name (First-Middle)	(Last)	
Address (Include apt. no., city, state and zip code) - **REQUIRED**	Social Security No.	License Number
	Date of Birth	Date Issued

I hereby authorize the licensing agency of _____ to furnish the information below to the State of Hawaii Board of Dental Examiners.

SIGN HERE: _____ Date: _____

TO BE COMPLETED BY LICENSING AGENCY:

LICENSING AGENCY ONLY

This is to certify that the above-named individual was issued license number _____ to practice as a dentist.

Social Security Number: _____

Date issued: _____

Date license/certificate expires: _____

Has this license/certificate ever been sanctioned in any way (revoked, suspended surrendered, limited, placed on probation, currently pending disciplinary action, being investigated)? . . . . . [ ] YES [ ] NO
*(Please explain "yes" response and **attach** copy of Board's order and related information.)*

Do your files contain any derogatory information on this applicant? . . . . . [ ] YES [ ] NO
*(Please explain "yes" response and **attach** copy of Board's order and related information.)*

COMMENTS:

Signature: _____

Title: _____

State: _____

Date: _____

BOARD SEAL

TO THE APPLICANT: Attach original with Board's seal to your application form, or the licensing agency may send directly to the Board.

THIS FORM MAY BE DUPLICATED

This material can be made available for individuals with special needs. Please call the Licensing Branch Manager at (808) 586-3000 to submit your request.

Print Form