VERIFICATION OF ACTIVE CLINICAL DENTAL PRACTICE

State of Hawaii, Board of Dentistry

Access this form via website at: **cca.hawaii.gov/pvl/boards/dentist**

The applicant named below has applied for a community service license with the Board of Dentistry. The applicant can qualify for the community service license by passing the appropriate National Board Examination within the last 5 years **or** provide evidence of active practice of clinical dentistry of not less than 1,000 hours per year for the 3 years immediately prior to the date of application. To verify the active practice of dentistry, this form shall be completed by a **licensed** dentist or dental hygienist and mailed to:
Board of Dentistry, P.O. Box 3469, Honolulu, Hawaii 96801.

NAME OF APPLICANT:	VERIFIER IS A LICENSED: ☐ DENTIST ☐ DENTAL HYGIENIST STATE OF LICENSE: _____ LIC. NO.: _____
PERIOD VERIFYING: FROM _____ (MONTH/YEAR) TO _____ (MONTH/YEAR)	Total hours per year verifying: _____

PROVIDE A DESCRIPTION OF APPLICANT'S DENTAL PRACTICE:

I hereby certify that I have personal knowledge of the applicant's active clinical hours of experience, as described above during the 3 years immediately prior to the date of application.

_____
Signature of Verifier

Print Name: _____

Address: _____

_____

Phone: _____

Date: _____

Print Form

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.