



If applying via Residency, the following form must be completed.

CERTIFICATE OF DIRECTOR OF DENTAL RESIDENCY PROGRAM

ATTESTATION

I am the Director of _____.
(Residency Program)

This is a dental residency program accredited or approved by the Commission on Dental Accreditation and is administered by an accredited dental college or hospital, specifically _____.
(Name of Dental College or Hospital)

As Director of the aforementioned dental residency program, I attest that _____ has **satisfactorily completed** this program, and has demonstrated a level of competency in dentistry which in my opinion qualifies _____ for a license to practice dentistry in the state of Ohio.
(Name of Applicant)

PROGRAM DIRECTOR:

Printed Name

Signature

NOTARY:

Signed and sworn before me this _____ day of _____, 20____.

Signature of Notary Public: _____

Expiration Date of Commission: _____

(Notary Seal)