

AMERICAN DENTAL BOARD OF ANESTHESIOLOGY

Application for Repeat Oral Examination



(Print clearly or use typewriter)

Name _____

Home Address _____

Work Address _____

Office Phone _____ Fax _____

Mobile _____ Email _____

When have you taken past ADBA Oral Examinations? _____

Months/Years

Which examination date/location are you applying for? _____

Have there been any restrictions to any dental licenses/general anesthesia permits since your last application to ADBA? Yes No

If Yes, describe on a separate piece of paper.

Copies of current Basic Life Support – Health Care Provider Level and Advanced Cardiac Life Support completion cards must be enclosed.

I certify that the above information is accurate to the best of my knowledge and that I have made no false or misleading statements. I understand that inaccurate information will invalidate my application and that false or misleading information will disqualify me from this or any future applications to the ADBA. I understand and agree that submission of this application authorizes the ADBA, its officers and agents to take whatever steps are necessary to authenticate and verify the information provided on this application.

Signature _____ Date ____/____/____

See Below for Payment Options

Send this application, supporting documents and \$500 non-refundable application fee to:

Norma Claassen, CAE
ADBA Executive Director
1345 Grand Avenue, Suite 102
Piedmont CA 94610
Off: (510) 547-7130
Fax: (510) 547-7191
acds@sbcglobal.net

Payment Options: **Check Payable to ADBA** **Visa** **MasterCard**

Card # _____

Expiration Date: Month _____ Year _____ 3 Digit Auth Code: _____

Signature: _____

Billing Address: _____
