

LICENSURE OVERVIEW COMMITTEE REPORT

You have been scheduled to meet with the Licensure Overview Committee. The committee requires this form be completed and submitted back to the board office **within 5 days of receipt** and prior to your appointment. Please complete **all sections** of the form, provide all supporting documents (copies of CE certificates, etc.) and fax to 1-866-888-1308. **If you do not submit this information, the committee may cancel your appointment. They will not make a decision concerning your licensure and additional appointments will be required.**

Print Name _____ Professional Title _____

(DDS,DMD,RDH)

Current application on file (if applicable) _____ Yes _____ No

Georgia License # (if applicable) _____

Date License Issued _____

Dental/Dental Hygiene School _____

Date Started Dental/Dental Hygiene School _____ Date Graduated Dental/Dental Hygiene School _____

Reason for LOC Review _____

(Request for Termination of Probation, New Applicant, At Board's Request, Other)

If Review involves Termination of Probation from a Consent Order, please provide:

Docket Date of CO _____

Date Fine Paid _____ (If applicable)

CE Requirements Completed _____ Yes _____ No

Other Conditions Completed (List below all conditions of your order): _____

CONTINUING EDUCATION RECORD FOR LICENSURE OVERVIEW COMMITTEE (LOC)

If you have been notified to appear before the Board’s Licensure Overview Committee, **you must provide copies of CE certificates** and complete the following section pertaining to your continuing education. *(If you have graduated from dental school within the last year you are exempt from this requirement.)*

(If you are applying for licensure by credentials, you will need to submit copies of your continuing education requirement as required by that state along with the number of hours that are required by said state.)

Date	Course Title	Total Hours (Please Specify) S-Scientific N-Non-Scientific	Sponsor	On-site or Not on-site (Please Specify) O-On Site N-Not On Site (i.e. Journal or Internet)

CPR Type – Please check *all that apply & provide copy of each card* ()BLS ()ACLS ()PALS

Total Hours _____

I certify this to be a true and correct record of my continuing education activity for the above specified period.

Signature _____ Date _____

Please return this material to the Georgia Board of Dentistry within 5 days of receipt. If we do not receive this information as required, your LOC appointment is subject to cancellation without notice. Please submit via fax to 1-866-888-1308.

(For Board Staff Only) If Review Is Application Review:
Reason Board Referred to LOC (as based on the minutes)

Information verified by board staff
Staff initials_____ Date_____