**DENTAL LICENSE RENEWAL APPLICANT: PLEASE COMPLETE THE FOLLOWING FORM, AND SUBMIT IT TO COMPLETE YOUR RENEWAL PROCESS. PLEASE EMAIL IT TO dentistry@dch.ga.gov or upload during the online renewal process. PLEASE PRINT LEGIBLY.**

_____ _____

**Name** **License Number**

Submission of Census Data under O.C.G.A. § 43-11-11
Enacted on July 1, 2013 by the General Assembly of Georgia

House Bill 132 (HB132) provides that "the Board [of Dentistry] shall gather census data on each dentist and hygienist in this state. Such census data shall be obtained from each dentist and dental hygienist as part of the license renewal process on a biennial basis. Renewal of a license shall be contingent on completion and provision of a census questionnaire shall authorize the board to refuse to grant a license renewal, revoke a license, or discipline a licensee under Code Section 43-11-47."

Published under the authority of O.C.G.A. § 43-11-11, the Board requires you to complete the following five (5) questions.

**1. BASIC DEMPGRAPHIC INFORMATION**
Please Check: Male: _____ Female: _____

Please Print: Age: _____

**2. SPECIALTIES**
Are you a General Dentist? Yes: _____ No: _____

If no, please indicate area of Specialization:

Endodontics: _____
Oral and Maxillofacial Pathology: _____
Oral and Maxillofacial Radiology: _____
Oral and Maxillofacial Surgery: _____
Orthodontics: _____
Periodontics: _____
Pediatric Dentistry: _____
Prosthodontics: _____

**3. WORK SCHEDULE:** Please indicate the number of hours you are involved in clinical practice in Georgia per week.

A. ____ 0-16 hours/week
B. ____ 16-32 hours/week
C. ____ more than 32 hours/week
D. ____ I do not currently practice in Georgia

**4. GEOGRAPHIC INFORMATION:** Please identify the name of the organization for which you practice, its physical address including zip code, and the name(s) of the practice owner(s).

Practice Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Practice Owner(s): _____

License Number(s) of the Practice Owner(s): _____

Practice Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Practice Owner(s): _____

License Number(s) of the Practice Owner(s): _____

Practice Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Practice Owner(s): _____

License Number(s) of the Practice Owner(s): _____

**5. GENERAL SUPERVISION OF DENTAL HYGIENISTS:** Please review O.C.G.A. § 43-11-74 and Board Rule 150-5-.03 for detailed information on this subject.

Have you authorized any of your dental hygienists to work under general supervision?
Yes: _____ No: _____

If yes, please indicate the settings for which you have provided such authorization:

Private Office _____
Hospitals _____
Nursing Homes _____
Long-Term Care Facilities _____
Rural Health Clinics _____
Federally Qualified Health Centers _____
Health Facilities operated by federal, state, county or local governments _____
Hospices _____
Family Violence Shelters (as defined by O.C.G.A. § 19-13-20) _____
Free Health Clinics (as defined by O.C.G.A. § 51-1-29.4) _____