# GEORGIA BOARD OF DENTISTRY

**2 Peachtree Street, N.W.**
**6th Floor**
**Atlanta, Georgia 30303**

## CONSENT FORM

I hereby authorize the Georgia Board of Dentistry ("Board") to receive any Georgia criminal history record information pertaining to me which may be in the files of any state or local criminal justice agency in Georgia.

_____
Full Name (Print)

_____
Physical Address (P.O. Boxes NOT Accepted)

_____
City, State, Zip

| _____ | _____ | _____ | _____ |
|---|---|---|---|
| Sex | Race | Date of Birth | Social Security Number |

**One of the following must be checked:**

☐ This authorization is valid for 90/180/___ (circle one) days from date of signature.

☐ I, _____ give consent to the Board to perform periodic criminal history background checks for the duration of my licensure with this state.

_____ _____
Signature of Applicant Date

Special licensure provisions (check if applicable):

____ Working with mentally disabled
____ Working with elder care
____ Working with children