



Georgia Board of Dentistry

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

(404) 651-8000

www.gbd.georgia.gov

Licensee Quarterly Self Report Form

Instructions to Licensee: Please complete this form to assist the Board of Dentistry in monitoring the compliance with your consent order. **ALL** reports should be mailed to the Board office by the 5th of the month following reporting period.

Reporting Period _____ (quarter ended)

Name of Licensee _____ License Number _____

Name of Practice or Place of
Employment _____

Street Address _____

City _____ State _____ Zip _____

Phone Number _____

Position _____

| Categories | |
|--|--|
| Current Home Address | |
| Current Home Phone Number | |
| Monitoring Physician | |
| Regular Physician | |
| Aftercare Provider | |
| In Compliance? (circle) If No, please explain below | Yes <input type="checkbox"/> No <input type="checkbox"/> |

Additional Comments _____

Name: _____

Signature: _____

Date: _____