Georgia Board of Dentistry
A Division of the
Georgia Department of Community Health

Date: _____/_____/_____

IP Registry Applicant:

Name: _____

License Number: _____

Facility Address(es): _____

_____

Phone Number: ( ) _____-_____

Email address: _____

Have you been sanctioned by this Board or any other regulatory Board? __yes ___no

If yes, please provide letter of explanation.

Date of Program: _____/_____/_____ Please attach certificate(s) of completion.

GBOD-approved Program Name: _____

Program Director: _____

Program Site: _____

Address: _____

Phone Number: ( ) _____-_____

Email address: _____

Check if applicable:

_____I have successfully completed an ADA accredited oral and maxillofacial surgery advanced specialty education.

Ethics Statement:

I certify that I have satisfied each of the requirements of the Laws and Rules that govern the Administration of Injectable Pharmacologics. I further certify that I will continue to treat my patients within the parameters described by the Georgia Board of Dentistry for the Administration of Injectable Pharmacologics. I understand that my privilege to provide these services may be suspended and my dental license sanctioned if I should violate the Laws and Rules that define the Dental Practice Act of Georgia.

_____ _____

IP Registry Applicant's Signature Date

The following checklist items must be submitted in order to be considered for the IP Registry:

_____1. Completed Injectable Pharmacologics Registration Form

_____2. $100 Fee

_____3. Certificate of Completion of Board-Approved Injectable Pharmacologics Course

_____4. OMFS Credentials, if applicable

Mail to:
GEORGIA BOARD OF DENTISTRY
A Division of the Georgia Department of Community Health
2 Peachtree Street, N.W., 6th Floor
Atlanta, GA 30303