ARKANSAS STATE BOARD OF DENTAL EXAMINERS
101 East Capitol Avenue, Suite 111
Little Rock, Arkansas 72201
Phone: 501-682-2085 Fax: 501-682-3543
Web: asbde.org Email: asbde@arkansas.gov

Request for Verification of License or Registration

Complete this form if you are requesting an official verification of your license or registration to be sent to another entity or state licensing agency. Mail this form along with your $25 check/money order made payable to "ASBDE" to the above address.

A. MY INFORMATION

First Name Middle Name Last Name

Address: (Street or PO Box) City State Zip

Phone # Email Address

I am requested verification of the following (check one):

☐ Dental license (License #: _____)

☐ Hygiene License (License #: _____)

☐ Dental Assisting Permit (Permit #: _____)

B. RECIPIENT INFORMATION

Name and address where you want your verification letter to be mailed to:

Name/Organization			
Address	City	State	Zip

☐ Check here if you want your license verification letter to be sealed within another envelope.

_____ _____

Signature *Date*