American Board of Dental Sleep Medicine

2019 Certification Exam Application for Reapplicants

Last Name First Name MI Degree

Mailing Address

City State/Province Zip/Postal Code

All correspondence will be sent to the above address, including examination results

Office Telephone Home Telephone

Fax E-mail

Current License (*Please include a copy of your current state license registration to practice dentistry or certificate*)

License or Certificate # State/Country Expiration Date

Have you ever had a license to practice dentistry/medicine suspended or limited? ❑ Yes ❑ No

If yes, explain on a separate sheet

Applicant Category

Please select the applicant category that applies to you. Eligibility requirements for each of the categories are described in the certification guidelines available at www.abdsm.org.

- ❑ Clinical Applicant
- ❑ Academic Applicant
- ❑ International Certificant Applicant

Fee

I am enclosing the examination fee. I understand that $395 of this fee will be refunded if my application is rejected and $395 will be refunded if notification of withdrawal is received by the ABDSM no later than January 25, 2019. I understand that refunds for late withdrawals will be made at the discretion of the ABDSM.

Authorization and Release

I hereby authorize the American Board of Dental Sleep Medicine to consult with the individuals I have named in my application or with whom I have otherwise been associated who may have information bearing on my qualifications to sit for the examination. I hereby release from liability all such individuals who provide information to the American Board of Dental Sleep Medicine, in good faith and without malice, concerning my professional training and competence, ethics, and other qualifications to sit for the examination.

Declaration

I hereby represent and warrant that (i) all information contained within this application and all documentation submitted with or in support of this application is true and correct; (ii) I am the direct and primary care provider of oral appliances for all case studies to be provided in support of my application; and (iii) I have read the ABDSM Examination Confidentiality & Applicant Conduct Policy and agree to abide by its terms. I understand and agree that my breach of any of the representation and warranties set forth above will result in my disqualification to sit for the examination, revocation of the certification obtained or other appropriate sanctions.

Signature Date

Payment (*Please check one*)

❑ VISA ❑ MasterCard ❑ Check (US Funds Only) Payable to: ABDSM Card Number

Exp. Date

Printed Name V-Code

Signature Date

American Board of Dental Sleep Medicine, 1001 Warrenville Road, Suite 175, Lisle, IL 60532
Phone: (630) 686-9875 Fax: (630) 686-9876