The University of the State of New York
The State Education Department
Office of the Professions
Division of Professional Licensing Services
www.op.nysed.gov

Dentist Form 4B
Certification of Completion of Residency Program

Applicant Instructions

You may complete either a specialty dental residency program or a general dentistry residency program. **The program must be at least one year's duration and accredited by a national accrediting body approved by the Department.** Please confirm with your residency program director that the residency program is participating in this route to licensure.

1. Complete Section I. In item 3, enter your name as it appears on your Application for Licensure (Form 1). Be sure to sign and date item 8.
2. Have your residency program director complete Section II certifying your successful completion of the residency program. The residency program director must return both pages of this form directly to the Office of the Professions at the address at the end of this form. This form will not be accepted if submitted by the applicant.

Section I: Applicant Information

1. Social Security Number
(Leave this blank if you do not have a U.S. Social Security Number)

2. Birth Date Month Day Year

3. Print Name
Last
First
Middle

5. Telephone/Email Address
Daytime Phone
☐ Home or ☐ Business
Area Code Phone

Email Address (please print clearly)
☐ Home or ☐ Business

Licensee business address, phone and email address are public information. Failure to indicate business or home on this form for each item will deem it public information.

4. Mailing Address ☐ Home or ☐ Business
(You must notify the Department within 30 days of any address or name changes)
Line 1
Line 2
Line 3
City
State ZIP Code
Country/ Province

6. New York State DMV ID Number (Driver or Non-Driver ID)
(Leave this blank if you do not have a New York State DMV ID Number)

7. Name of hospital, school or facility where you completed the residency program (please type or print)

Name of accredited residency program

Dates of residency program From ____ mo. ____ day ____ yr. To ____ mo. ____ day ____ yr.

8. I request and give my permission to the hospital, school or facility listed in item 7 above to complete Section II of this form and mail it to the Office of the Professions at the address at the end of this form, and to release any other information requested by the State Education Department in connection with my application.

Signature Date

Section II: Dental Residency Program Certification

Instructions: As a dental residency program director you must review §6601 of New York State Education Law below. Check the appropriate type of residency program in item 1. Read, sign and date the certification in item 2. Send all pages of the completed form to the address at the end of the form.

Definition of practice of dentistry (NYS Education Law §6601). The practice of the profession of dentistry is defined as diagnosing, treating, operating, or prescribing for any disease, pain, injury, deformity, or physical condition of the oral and maxillofacial area related to restoring and maintaining dental health. The practice of dentistry includes the prescribing and fabrication of dental prostheses and appliances. The practice of dentistry may include performing physical evaluations in conjunction with the provision of dental treatment.

Name of the applicant _____
(see Section I, item 3)

Date entered residency program ____ ____ ____ (mo. day yr.) Date completed residency program ____ ____ ____ (mo. day yr.)

1. Check appropriate box to indicate residency program completed.

- ☐ Endodontics
- ☐ Oral & Maxillofacial Pathology
- ☐ Oral & Maxillofacial Radiology
- ☐ Oral & Maxillofacial Surgery
- ☐ Orthodontics & Dentofacial Orthopedics
- ☐ Periodontics
- ☐ Pediatric Dentistry
- ☐ Prosthodontics
- ☐ General Practice (GPR)
- ☐ Advanced Education in General Dentistry (AEGD)
- ☐ Dental Anesthesiology
- ☐ Dental Public Health
- ☐ Orofacial Pain
- ☐ Oral Medicine

2. I am the residency program director and I hereby certify that: **1)** The statements made on this form regarding this applicant's residency experience are true, complete and correct; **2)** The applicant has successfully completed this dental residency program of at least one year's duration in the area indicated above; **3)** The resident has competently completed the above mentioned residency program that includes an outcomes assessment that satisfactorily allows the resident to comply with section 6601 of the New York State Education Law. Residency Program Director's

_____ _____
Signature Date

Print Name _____

License Number _____ State in which you are licensed _____

Hospital or school name _____

Address _____

City _____ State _____ Zip Code _____

Telephone _____ Fax _____ Email _____

Return Directly to: New York State Education Department, Office of the Professions, Division of Professional Licensing Services, Dentistry Unit, 89 Washington Avenue, Albany, NY 12234-1000. **OR, Submit this form to the Department by E-mail at DPLSExperience@nysed.gov.**