

Section II: Verification of Full-time Employment

Instruction to Dean: Complete this section, be sure to sign and date the Attestation below and mail the entire form to the Office of the Professions at the address at the end of the form. This form will not be accepted if returned by the applicant.

Both you and the applicant must notify the Department in within thirty days if the applicant is terminated from full-time employment.

This form must be submitted yearly.

1. Name of applicant: _____
(Section I, item 3)

2. Full-time employment means the holder of such restricted dental faculty license devotes at least four full working days per week in teaching or patient care, research or administrative duties at the dental school where employed.

Is the applicant named above employed full time? Yes No

Date which applicant began employment: _____ / _____ / _____
mo. day yr.

Attestation

I hereby attest that to the best of my knowledge and belief the foregoing is a true statement of the record of the applicant named on this form.

Signature of Dean: _____ Date: _____ / _____ / _____
mo. day yr.

Print name: _____

School: _____

Address: _____

(SEAL)

City: _____ State _____ Zip Code _____

Telephone: _____ Fax: _____

E-mail Address: _____

Return Directly to: New York State Education Department, Office of the Professions, Division of Professional Licensing Services, Board of Dentistry, 89 Washington Avenue, Albany, NY 12234-1000.