

**Dental Residency Registration Roster**  
 Certification of Eligibility for Exempt Status as a Dental Resident

\_\_\_\_\_  
 Name of residency program approved by the Commission on Dental Accreditation

\_\_\_\_\_  
 Address of residency program

\_\_\_\_\_  
 Program Specialty

\_\_\_\_\_  
 Beginning and end date of program

**Instructions**

The residency director of a general or advanced specialty residency program approved by the Commissioner on Dental Accreditation (CODA) shall certify to the State Education Department, Office of the Professions, those residents eligible to be considered exempt from licensure pursuant to Education Law §6605(5).

Attached to this form should be an individual check for each eligible resident made payable to the New York State Education Department in the amount of \$105. The check number must be provided in the check number column to ensure the proper processing of the fee. The fee is payable annually for each academic year of the duration of the program as approved by CODA.

This form should be submitted no later than sixty days following the start of a resident's program. Forms may be submitted throughout the academic year.

**This form is intended only for submission by the residency director. Attach additional sheets as necessary.**

**All students with less than a 4-year U.S. or Canadian DDS/DMD must complete and submit a Dental Education Record Form, and must request that their college or university mail Form 2 (Certification of Professional Education) directly to the Office of the Professions with an official transcript.**

Last Name, First Name	Social Security Number	Date of Birth (mm/dd/yy)	Date Doctoral Degree in Dentistry Awarded (mm/dd/yy)	Institution Awarding the 4 year DDS/DMD	4 Year U.S. or Candadian dental degree	ADA Accredited*	Check Number
					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
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					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	

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Last Name, First Name	Social Security Number	Date of Birth (mm/dd/yy)	Date Doctoral Degree in Dentistry Awarded (mm/dd/yy)	Institution Awarding Doctoral Degree in Dentistry	International Dental Program	ADA Accredited*	Check Number
					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
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					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
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					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	

**\*Note:** If a resident has not graduated from an ADA accredited dental school, his or her educational qualifications must be reviewed by the Department's Office of Comparative Education. Residents should not be considered exempt until this review is complete. This review requires receipt of transcripts directly from the resident's home institution accompanied by a Certification of Professional Education (Form 2), and should therefore be commenced as soon as possible after the resident has been selected for your program. Please access the Department's Web site at [www.op.nysed.gov](http://www.op.nysed.gov) for instructions regarding this process.

Based upon the instructions found at [www.op.nysed.gov](http://www.op.nysed.gov), each of the individuals above are eligible to be considered exempt from licensure pursuant to Education Law §6605(5).

IN WITNESS WHEREOF, I hereunto set my hand and the seal of this school

This \_\_\_\_\_ day of \_\_\_\_\_ 20 \_\_\_\_\_

Signature of Residency Director: \_\_\_\_\_

Print or type name: \_\_\_\_\_

**(SEAL)**

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

E-mail: \_\_\_\_\_

**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**