Jeb Bush
Governor

FLORIDA DEPARTMENT OF HEALTH

M. Rony François,M.D.,M.S.P.H,Ph.D.,Secretary

FLORIDA STATE BOARD OF DENTISTRY
RESIDENCY/INTERN APPLICATION
CHAPTER 466.025(1), FLORIDA STATUTES
RULE 64B5-7.001 and 7.003, FLORIDA ADMINISTRATIVE CODE

This application is pursuant to the above statute and rule. Any question not applicable must be indicated accordingly (N/A). Institutions may copy this application. The Florida State Board of Dentistry will not consider incomplete applications or faxed copies that are not legible. Please type all responses.

Name of resident/intern _____**Date of birth**_____

Social Security Number_____

Telephone day ( )_____**Telephone Evening ( )**_____

Dental school attended_____**DDS or DMD**
Please circle degree awarded

Date of graduation_____ **Anticipated date**_____

Name of institution seeking approval **Univ. of Florida College of Dentistry**

Mailing address **PO Box 100407**

Gainesville FL 32610-0407

Telephone (352) **273-5950** **Contact person/Title** **Timothy Wheeler, DMD, PhD, Asst. Dean, Adv. & Graduate Ed.**

THIS INFORMATION IS TO BE COMPLETED BY THE INSTITUTION SEEKING APPROVAL

Please answer questions completely.

DISCIPLINARY AND MALPRACTICE ACTIONS IN ANY OTHER STATE OR JURISDICTION

(A) Is the applicant licensed as a dentist in any other state or jurisdiction? If yes. list state(s).
Yes No _____

(B) Have disciplinary actions been brought against applicant's license in another state or jurisdiction? If yes, provide final disposition documents.
Yes _____ **No** _____

(C) Have malpractice actions been brought against applicant's license? If yes, provide final disposition documents.
Yes _____**No** _____

(D) Is this an initial permit? Yes _____ No _____

(E) If no, when did you enter the residency program?_____

(F) Name/Type of residency program_____

Name(s) and license number(s) of Florida licensed dentist(s) providing supervision

Name_____Dr. Timothy Wheeler_____License Number__DN 10667_ ___
Name_____License Number_____
Name_____ License Number_____

Please attach a copy of applicant's diploma and/or final official transcripts from graduating dental school.

THIS APPLICATION WILL NOT BE CONSIDERED UNLESS A DIPLOMA OR FINAL TRANSCRIPT IS ATTACHED

Please attach proof of current CPR training at the basic life support level.

On behalf of this institution, I certify that the information provided on this application is true and accurate to the best of our knowledge.

_____ _____
Resident Director or Chief **Date**

I declare under penalty of perjury that the answers provided on this application are true and accurate. I agree that submission of false information by any party completing this application shall constitute cause for the denial, suspension, or revocation of this permit or dental license to practice in the state of Florida.

Pursuant to rule 64B5-7.003, F.A.C., I acknowledge that experience obtained pursuant to a permit issued under the authority of this rule and section 466.025, F.S., is not acceptable for the purpose of fulfilling the supplemental education program set forth in section 466.006(3)(c), F.S.

_____ _____
Signature of applicant **Date**