

IDAHO BOARD OF DENTISTRY
PO BOX 83720
BOISE, ID 83720-0021
PH #: (208) 334-2369 FAX #: (208) 334-3247
LICENSE VERIFICATION REQUEST FORM

I hereby make request for an official verification of license.

REQUESTOR NAME: _____

LICENSE NUMBER: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE NUMBER: _____

EMAIL: _____

Please mail this verification to (if different from above):

NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

To email this form, click

To print and mail or fax this form, click

<p>FOR BOARD USE ONLY:</p> <p>Date Received: _____</p> <p>Completed By: _____</p>
--