

APPLICATION FOR LIMITED CONTROLLED SUBSTANCES REGISTRATION
DENTAL RESIDENT

PART I - CERTIFICATION BY APPLICANT

I, _____, certify that I am a licensed dentist in the State of _____, and currently possess a valid and current license to practice Dentistry in that State, having been assigned registry number _____ by the licensing board of that State. I further certify that I am a bona fide full-time resident in a postdoctoral advanced dental education program at the College of Dental Medicine of the Medical University of South Carolina.

Signature of Applicant

Sworn to and subscribed before

me this ____ day of _____

at _____, S. C.

Notary Public for South Carolina

My Commission expires: _____

PART II - CERTIFICATION OF RESIDENCY

This is to certify that _____ is a full-time resident in a postdoctoral advanced dental education program at the College of Dental Medicine, Medical University of South Carolina, and that such program has been approved by the Council on Dental Education of the American Dental Association.

The applicant is enrolled in the postgraduate residency program in _____.

The resident is enrolled as a full-time resident as of _____, 20 ____ .

The anticipated program completion date is _____, 20 ____ .

Dean, College of Dental Medicine
Medical University of South Carolina

_____, 20____

PART III - APPROVAL BY THE SOUTH CAROLINA STATE BOARD OF DENTISTRY

This is to certify that the South Carolina State Board of Dentistry has this date approved _____ as an applicant for temporary registration under the provisions of the South Carolina Controlled Substances Act for dispensing privileges relating to use of controlled substances within the postdoctoral advanced dental education program at the College of Dental Medicine, Medical University of South Carolina.

Administrator
South Carolina State Board of Dentistry

_____, 20____