STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
VERIFICATION OF DENTAL RESIDENCY TRAINING

APPLICANT: Enter your full name and birth date on this form and forward it to the Chief of Staff or program director at the facility at which you completed residency training. This form must be completed by the facility and returned directly to this office.

Applicant's name:_____ Date of Birth:_____

Dear Chief of Staff/Program Director:

Please provide the following verification of residency training for the above-named Connecticut dental licensure applicant.

Name of facility where residency training was completed: _____

Dates of Residency: From_____ To_____
month/day/year (month/day/year)

In what specialty was the residency training completed: _____

At what level(s) was this residency completed (PGY1, PGY2, etc.)? _____

At the time of the applicant's training, was the residency training program in this specialty area accredited by the Commission on Dental Accreditation? ☐ **Yes** ☐ **No**

Did the applicant satisfactorily complete this period of residency training?_____ **(YES or NO)**

I certify that the above named dentist has demonstrated competency in the following subject areas related to the practice of dentistry during this period of this residency training (please place a check box in the appropriate column):

Subject Area	Yes	No
Diagnosis, Oral Medicine and Radiology • Anatomical identification • Abnormalities of bone, soft tissue • Identification of systemic conditions • Radiology techniques/errors • Physical evaluation/laboratory diagnosis • Therapeutics		
Comprehensive Treatment Planning • Preventative Dentistry/Periodontics • Systemic Disease/Medical Emergencies/Special Care • Oral Medicine/Therapeutics • Endodontics • Orthodontics/Pediatric Dentistry • Restorative Dentistry • Oral Surgery		
Periodontics, Prosthodontics and Medical Considerations • Periodontal Diagnosis • Fixed Partial Dentures • Removable Partial Dentures • Complete Removable Dentures • Evaluation of Laboratory Procedures • Medical Considerations		
Access opening on a posterior tooth		
Access opening, canal instrumentation and obturation on an anterior tooth		
Cast metal crown preparation		
Porcelain-fused to metal crown preparation as an abutment for a three unit bridge		
Ceramic crown preparation		
Class III composite restoration		
Class II amalgam preparation		
Class II amalgam restoration		
Infection control and disease barrier techniques		

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(Continued)

I, _____, certify that I am the Chief of Staff/Program Director at:

Name of Facility: _____

Address: _____

_____

Telephone Number: _____

and that the information provided herein is true and correct to the best of my knowledge and belief.

_____
Signature of Chief of Staff/Program Director

Subscribed and sworn to me this _____ day of _____ (month/ year)_____

_____ _____
Notary Public's Signature My Commission Expires

Please return this form directly to:

Department of Public Health
Dental Licensure
410 Capitol Ave., MS # 12 APP
P.O. Box 340308
Hartford, CT 06134-0308
Fax: (860) 707-1929