

MONTANA BOARD OF DENTISTRY
PO BOX 200513
(301 S PARK, 4TH FLOOR - Delivery)
Helena, Montana 59620-0513
(406) 841-2390 or 2331 FAX (406) 841-2305
EMAIL: dlibsdden@mt.gov WEBSITE: www.dentistry.mt.gov

CERTIFICATION OF HOURS

(Use for DENTAL HYGIENE CREDENTIALING APPLICANTS, inactive to active practice, or volunteer license)

Applicant Name _____

Today's Date _____

Dates Worked: From _____ To: _____

Full-time or Part-time and Total hours worked: _____

Employer Signature _____ Date _____

If the applicant had more than one employer during this period of time, the applicant should make copies of this form and have each employer verify the work experience on this form.

Employer's Name _____
Please Print

Employer's Address _____

Employer's Telephone Number _____

I hereby declare under penalty of perjury that information submitted on this form is true and complete to the best of my knowledge. In signing this form, I am aware that a false statement or evasive answer may lead to denial of my application or subsequent revocation of licensure on ethical grounds.

Applicant's Signature

Date