



BOARD OF DENTISTRY
PO BOX 200513
(301 S PARK, 4TH FLOOR - Delivery)
Helena, Montana 59620-0513
(406) 444-6880
EMAIL: dlibsdhhelp@mt.gov
WEBSITE: www.dentistry.mt.gov

CERTIFICATION OF HOURS

Use for Dental/Hygiene Credentialing Applicants, Inactive to Active Practice, or Volunteer License. This form is not for Restricted Non-Resident Volunteer License.

Applicant Name: _____

Applicant's Address: _____

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: _____

Employer's Address: _____

Employer Email & 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