AADB
American Association of Dental Boards
www.dentalboards.org

SELF-QUERY

INSTRUCTIONS

This form is fillable. Type directly into the form. If you elect not to type, print **legibly** in ink. Unless noted "if any," ***all information is required*** and must be completed in order to process the self-query. ***This form must be notarized***. Notaries can be found at a bank or currency exchange.

This form may not be faxed or emailed. Mail an original copy of this form to the address below. Enclose a $25 check or money order made payable to the American Association of Dental Boards ***or*** provide the required credit card information. If paying with a money order, remember to sign the front. A report will be mailed to you in an envelope within 10 business days from the date of receipt. For expedited service, enclose a pre-paid overnight label or pre-paid envelope. ***Upon receipt, do not open the AADB envelope***. Provide the sealed envelope to your state dental board.

Texas Dental Assistants: If you are a first-time, unregistered dental assistant, the Texas State Board of Dental Examiners no longer requires an AADB Self-Query, unless applying for a nitrous oxide permit. For more information, contact the Texas State Board of Dental Examiners at (512) 463-6400 or info@tsbde.gov.

LAST NAME ______________________ FIRST NAME ______________________ MIDDLE INITIAL ________

PREVIOUS NAMES (if any) ______________________

MAILING ADDRESS ______________________ APT/UNIT # ________

IF ABOVE ADDRESS IS A BUSINESS/COMPANY, ENTER COMPANY NAME (if any) ______________________

CITY ______________________ STATE ______________ ZIP ______________

PHONE (_______) ________ - ______________ EMAIL ______________________

DATE OF BIRTH (mm/dd/yyyy) ______________________

PROFESSIONAL SCHOOL ATTENDED (if any) ______________________

PROFESSIONAL SCHOOL CITY AND STATE (if any) ______________________

YEAR OF GRADUATION (if any - yyyy) ______________ (Dental assistants: If no school, enter the year your training was competed)

DEGREE/CREDENTIAL/OTHER ☐ DDS ☐ DMD ☐ RDH ☐ RDA or DA

DENTAL LICENSE NUMBER(S) (if any) ______________________ ISSUING STATE(S) ____________

The reliability of reports produced by the AADB Clearinghouse for Board Actions relies upon the accuracy and timeliness of information provided by the reporting entities. AADB makes no representations or warranties, either expressed or implied, as to the accuracy of the information and will assume no responsibility for errors or omissions that may be contained therein.

NOTARIZATION

____
YOUR SIGNATURE

____
DATE

____
NOTARY PUBLIC SIGNATURE

(NOTARY SEAL)

SIGNED BEFORE ME THIS DATE ______________

MY COMMISSION EXPIRES ______________

PAYMENT

Enclose a $25 check or money order payable to the American Association of Dental Boards ***or*** provide credit card information below.

Payment Type ☐ Check/Money Order ☐ Visa ☐ MasterCard ☐ American Express

Card Number ________ ________ ________ ________ Expiration Date (mm/yy) ______________

Name on Card ______________________ Billing Zip Code ______________

MAIL THIS FORM TO:
American Association of Dental Boards
211 E. Chicago Avenue, Suite 760
Chicago, IL 60611
(312) 440-7464