AADB
American Association of Dental Boards
www.dentalboards.org

SELF-QUERY

INSTRUCTIONS

Type directly into this form or 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.

Mail the **original** of this form to the address below. Enclose a $25 check or a ***signed*** money order made payable to the American Association of Dental Boards ***or*** provide the required credit card information. A report will be mailed to you in a sealed envelope within 10 business days from the date of receipt. An additional $12.00 will guarantee that reports will be processed and mailed back within 72 hours of receipt. ***Without opening,*** provide the **sealed** envelope to your state dental board.

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

☐ **Notice:** An additional $12.00 will guarantee that your report will be processed and mailed back within 72 hours of receipt. Enclose a $37.00 money order payable to the American Association of Dental Boards or authorize credit card payment by checking the box if you wish to expedite your report.

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