



Dental Quality Assurance Commission
 Credentialing
 P.O. Box 47877
 Olympia, WA 98504-7877
 360-236-4700

Proof of Practice

Demographics:		
Name: First	Middle	Last
Washington Credential #, if applicable		Date of Birth
Location of Practice		
<input type="checkbox"/> I certify that I am in the practice of dentistry at the following location, I further certify I have practiced dentistry, as defined in RCW 18.32.020 , for at least a minimum of twenty hours per week for the four years proceeding this application in another U.S. State or territory.		
Business Name: _____		
Address: _____		
City: _____ State: _____ Zip Code: _____		
From: _____ to _____ (mm/dd/yyyy) (mm/dd/yyyy)		
Note: Please complete an additional form(s) for each location worked within the last 4 years.		
Federal Tax No: _____ State Tax No: _____		
<input type="checkbox"/> I certify that I am a dentist serving in the United States federal services. I will submit a letter from my commanding officer outlining my duties, length of service and whether any adverse actions have been reported or taken.		
<input type="checkbox"/> I certify that I am a dentist employed by a dental school, I will submit documentation from the dean or the appropriate administrator of the institution regarding the length, terms of employment, responsibilities and any adverse actions or restrictions.		
<input type="checkbox"/> I certify that I am a dentist in a dental residency program, I will submit documentation from the director or the appropriate administrator of the residency program regarding the length of the residency, duties and responsibilities and any adverse actions or restrictions.		
Applicant's Signature: _____		Date: _____