



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

Residency Verification

Please complete the top section of this form and send it to the residency program.
 This form must be submitted to the Department of Health directly from the residency program.

Demographics: To be completed by the applicant		
Name First	Middle	Last
Washington Credential #, if applicable		Date of Birth
Address		
City	State	Zip Code
Applicant's Signature _____		Date _____
Residency Verification: To be completed by the residency program		
I certify that the above named applicant completed a qualifying residency program.		
The completed residency program met the following requirements:		
<ul style="list-style-type: none"> • Residency Type: <ul style="list-style-type: none"> <input type="checkbox"/> General practice residency; <input type="checkbox"/> Pediatric residency; Or <input type="checkbox"/> Advanced education in a general dentistry • The residency was located in Washington State and was accredited by the Commission on Dental Accreditation of the American Dental Association. • The residency was at least one year • The residency was a program that served predominantly low-income patients. 		
Residency Name		
Residency Address		
City	State	Zip Code
Start Date (mm/dd/yyyy)		End Date (mm/dd/yyyy)
_____ Name of director of dental residency program		
_____ Signature of director of dental residency program		_____ Date (mm/dd/yyyy)