



AMERICAN DENTAL BOARD OF ANESTHESIOLOGY

Application for Repeat Written Examination

Instructions: <ul style="list-style-type: none"> This form must be typewritten Submit additional required documents with this application If more space is required, attach additional sheets 	Date of application (mm/dd/yyyy)
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The repeat written examination fee is \$720. Completed application and full payment is due 60 days prior to the date of examination. Once a candidate is determined to be Board eligible, exam fees are NOT refundable or transferable.

Confirmation of acceptance for examination will be made once application is determined to be complete and fees have been paid. If further information is required, the applicant will be immediately notified. Notification may be made by phone and/or sent either electronically via email and/or by standard mail.

For complete information on the Exam process, please visit www.adba.org and click on Examinations.

<i>Identifying Information</i>				
Last Name	First Name	Middle Name	Birth Date (mm/dd/yy)	
Mobile #	Email			
Primary Address	City	State	Zip	Telephone
Work Address	City	State	Zip	Telephone

<i>Training Information</i>			
Dental School	Degree (DDS or DMD)	Year of Graduation (yyyy)	
Name of Graduating Anesthesia Program	Name of Program Director		
Address (Street)	(City)	(State)	(Zip Code)



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<i>Training Information (continued if applicable)</i>			
Name of Other Anesthesia Program		Name of Program Director	
Address (Street)	(City)	(State)	(Zip Code)
Additional anesthesia training program			
Other Residency Training (Type / Name / Start-End months)			
Other Board Certifications			
Current Dental License(s) (States & License Numbers)		Current Anesthesia Permit(s) (States & Permit Numbers)	



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Questionnaire

1. Have there been any restrictions to any dental licenses/general anesthesia permits?
 No Yes - If so, describe (use additional sheets if necessary)

2. Have there been, or are there currently pending, any malpractice claims, suits, settlements or arbitration proceedings involving your professional practice?
 No Yes - If so, describe (use additional sheets if necessary)

3. Date(s) of past ADBA written examinations:

_____ (mm/dd/yy)

_____ (mm/dd/yy)

_____ (mm/dd/yy)



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Signature Page

I certify that the above information is accurate to the best of my knowledge and that I have made no false or misleading statements. I understand that inaccurate information will invalidate my application and that false or misleading information will disqualify me from this or any future applications to the ADBA. I understand and agree that submission of this application authorizes the ADBA, its officers and agents to take whatever steps are necessary to authenticate and verify the information provided on this application.

Date (mm/dd/yyyy)

Signature of Applicant

Note: Complete applications and enclosure must be submitted before the deadline.

All applicants must include the following with application form:

1. Basic Life Support – Health Care Provider Level
2. Advanced Cardiac Life Support
3. Pediatric Advanced Life Support
4. NPDB query (USA applicants)
Letter of professional standing from provincial regulatory body (Canadian applicants)
5. Diploma from Dental School

#6, 7 & 8 if not previously submitted

6. Certificate from anesthesiology residency program
7. Dental license
8. General anesthesia permit



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Payment Options: Visa MasterCard / Check (mail to same submit address below)
Charge \$720.00

Card # _____

Expiration Date: Month _____ Year _____ 3 Digit Auth Code: _____

Billing Address:

Street: _____

City: : _____

State: : _____

Zip Code: : _____

Signature: _____

Submit options

Email
amysarno@adba.org

Mail
Attn: Amy L. Sarno
ADBA Executive Director
4411 Bee Ridge Road, #172
Sarasota, FL 34233