AMERICAN DENTAL BOARD OF ANESTHESIOLOGY
Application for Oral Examination

Instructions:	Date of application (mm/dd/yyyy)
• This form must be typewritten • Submit additional required documents with this application • If more space is required, attach additional sheets	

The oral examination fee is $1,800.00 which permits entrance to the initial oral examination. Completed application and full payment must be received within 120 days prior to the date of examination. Exam fees are non-refundable and
non-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.

Identifying Information				
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

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Questionnaire

1. When did you pass the ADBA written examination?
   - Date (mm/yyyy): _____
2. Which oral examination are you applying for?
   - Date (mm/yyyy): _____
   - Location (city, state): _____
3. Estimated number of anesthetics delivered independently since completing the ADBA written exam?
   - _____
4. Have there been any restrictions to any dental licenses/general anesthesia permits since your last application to the ADBA?

   ☐ No ☐ Yes - If so, describe (use additional sheets if necessary)

5. 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)

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Signature Page	
I hereby certify that I have met the requirement for six (6) months of independent anesthesia practice which I can support with documentation upon request by the ADBA.	
Date (mm/dd/yyyy)	Signature of Applicant
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.
Enclose 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
5. Certificate from anesthesiology residency program (if not already submitted for written exam)
6. Dental license where currently practicing
7. General anesthesia permit
   - or appropriate verification to provide general anesthesia where currently practicing

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Payment Options: ☐ **Visa** ☐ **MasterCard / ☐ Check (mail to same submit address below)** **Charge $1,800.00**

Card # _____

Expiration Date: Month_____Year_____ 3 Digit Auth Code:_____

Billing Address:

Street: _____

City: : _____

State: : _____

Zip Code: : _____

Signature: _____

Submit options		
Submit	Email amysarno@adba.org	Mail Attn: Amy L. Sarno ADBA Executive Director 4411 Bee Ridge Road, #172 Sarasota, FL 34233