SELF QUERY FORM

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. A report will be mailed to you in a sealed envelope within 10 business days from the date of receipt. For expedited service, enclose a pre-paid overnight label or pre-paid envelope.

LAST NAME_____ FIRST NAME_____

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) _____

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NOTARIZATION

_____ _____
YOUR SIGNATURE DATE

_____ (NOTARY SEAL)
NOTARY PUBLIC SIGNATURE

SIGNED BEFORE ME THIS DATE _____

MY COMMISSION EXPIRES _____

PAYMENT
Enclose a $25 check or money order payable to the American Association of Dental Boards ***or*** provide credit card information below.

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
200 East Randolph Street, Suite 5100
Chicago, Illinois 60601