



**EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES
DEPARTMENT OF PUBLIC HEALTH
DIVISION OF HEALTH PROFESSIONS LICENSURE
239 CAUSEWAY STREET, SUITE 500
BOSTON, MA 02114
800-414-0168
www.mass.gov/dph/boards**

**BOARD OF REGISTRATION IN DENTISTRY
REQUEST FORM**

*Use this form to request a name change, address change and/or request a duplicate license.
Mail requests to the address above to the attention of the Board.
Check all that apply:*

NAME CHANGE ADDRESS CHANGE DUPLICATE LICENSE

[NOTE: IF YOU ARE REQUESTING A NAME CHANGE AND HAVE A CURRENT OR EXPIRED LICENSE WITH ANOTHER BOARD(S) WITHIN THE DIVISION, THE REQUESTED NAME CHANGE WILL BE EFFECTIVE FOR ALL BOARDS.]

Print/type clearly the information as it
CURRENTLY SHOWS on your license:

Name: _____
Address: _____
City/Town: _____
State: _____

Print/type clearly the information as you
wish it to appear on your **NEW** license.

Name: _____
Address: _____
City/Town: _____
State: _____ **Zip Code:** _____

Board Code: DN DH (circle one)
Lic. No.: _____

Circle other professional licenses held: Nursing Pharmacy
Physician Assistant Respiratory Care Perfusion
Nursing Home Administrator

Lic. Type: _____
SSN (Mandatory): _____
Birth Date: _____
Expiration Date: _____

For official use only:	
Fee: _____	Date Received: _____
MLO Receipt #: _____	MLO Receipt Date: _____
Staff Signature: _____	

If your current license has been **lost or stolen**, please check here. _____

All addresses are subject to disclosure upon request, pursuant to MGL, Ch.4, Section 7.

My signature hereon attests under penalties of perjury that the information provided is truthful, complete and for lawful and honest purposes.

Signature

Telephone Number

Date

FEES:

- | | |
|--|----------------|
| 1. Duplicate License | \$17.00 |
| 2. Name change with new license | \$27.00 |
| 3. Address changes only | no fee |

**Make check or money order payable to the Commonwealth of MA.
DO NOT SEND CASH OR ELECTRONIC FUNDS TRANSFERS**