STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

REQUEST FOR WAIVER OF DENTAL LICENSE RENEWAL FEE

TO BE COMPLETED BY LICENSEE

I am requesting that my annual dental license renewal fee be waived pursuant to Section 10-113b, Connecticut General Statutes.

My signature confirms that I practice dentistry at a public health facility for no fee for a minimum of 100 hours annually and that I do not otherwise engage in the practice of dentistry. These conditions will remain unchanged throughout the next registration period.

_____ _____
Licensee Name (please print) ***License Number***

_____
Street Address ***City*** ***State*** ***Zip Code***

_____ _____
Date of Birth ***Social Security Number***

_____ _____
Signature ***Date***

_____ _____
Daytime Phone Number ***E-Mail Address***

Please note: this form must be submitted annually in addition to a completed renewal application.

TO BE COMPLETED BY EMPLOYER

This is to certify that the above dentist has provided a minimum of 100 annual hours of uncompensated dental care at our facility from _____ to _____.

Name and address of facility:

_____

_____

_____

_____

_____ _____
Name and title (please print) ***Signature***

_____ _____ _____
Daytime telephone number ***E-mail address*** ***Date***

Your prompt attention to this matter is appreciated, as the renewal process cannot be completed without the above information.

Please return this form directly to:

Department of Public Health
Dental License Renewal
410 Capitol Ave., MS# 12MQA
P.O. Box 340308
Hartford, CT 06134-0308
oplc.dph@ct.gov