Dental Quality Assurance Commission
Credentialing
P.O. Box 47877
Olympia, WA 98504-7877
360-236-4700

Residency Verification

Please complete the top section of this form and send it to the residency program.
This form must be submitted to the Department of Health directly from the residency program.

Demographics: To be completed by the applicant		
Name First Middle Last		
Washington Credential #, if applicable	Date of Birth	
Address		
City	State	Zip Code

Applicant's Signature _____ Date _____

Residency Verification: To be completed by the residency program

I certify that the above named applicant completed a qualifying residency program.

The completed residency program met the following requirements:

- Residency Type:
  - ☐ General practice residency;
  - ☐ Pediatric residency; Or
  - ☐ Advanced education in a general dentistry
- The residency was located in Washington State and was accredited by the Commission on Dental Accreditation of the American Dental Association.
- The residency was at least one year
- The residency was a program that served predominantly low-income patients.

Residency Name		
Residency Address		
City	State	Zip Code
Start Date (mm/dd/yyyy)	End Date (mm/dd/yyyy)	

_____
Name of director of dental residency program

_____ _____
Signature of director of dental residency program Date (mm/dd/yyyy)