



NEVADA STATE BOARD OF DENTAL EXAMINERS

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Certification of Specialty Program Completion

This is to certify that _____ (*Name of Student*)

attended the _____ program (*Name of Specialty Program*) at

_____ (*Accredited Educational Institution*)

for the period of _____ to _____. The participant

completed the program on _____ and received specialty certification in

_____ (*Name of Specialty*).

(Original Signature of Dean. No Stamped Signatures)

Printed Name of Dean

Date

*OFFICIAL SEAL OF THE
ACCRREDITED EDUCATIONAL
INSTITUTION*

***This form must be completed and returned by the educational institution only as primary source verification.**