



STATE OF MAINE
Board of Dental Practice
143 STATE HOUSE STATION
AUGUSTA, ME 04333-0143

Residency Program and Supervision Form

Resident Dentist Data		
Name of Resident/Applicant:		
Mailing Address:		
City:	State:	Zip Code:

Residency Program Information		
Name of Supervisor:	License Number	
Mailing Address:		
City:	State:	Zip Code:

Resident Dentist Supervisor's Statement	
1) Location(s) of the residency program: _____	
2) Duration(s) of the residency: _____	
3) Anticipated procedures to be completed under my supervision in coordination with the Dental Residency Program. The following procedures will be performed under the level of supervision as listed below:	
A.	General or Direct
B.	General or Direct
C.	General or Direct
D.	General or Direct
E.	General or Direct
F.	General or Direct
G.	General or Direct

By signing, I understand that the Maine Board of Dental Practice will rely upon this information to issue a resident dentist license to the applicant to perform procedures under my supervision. I also agree to not commence supervision of the practice of this applicant until the license is approved and issued by the Board.

SUPERVISOR'S SIGNATURE: _____ DATE: _____