



AMERICAN BOARD OF DENTAL SLEEP MEDICINE

2011 Certification Exam Application

Deadline: January 15, 2011 • Examination Fee: \$795

Last Name _____ First Name _____ MI _____ Degree _____

Mailing Address _____

Mailing Address _____

City _____ State/Province _____ Zip/Postal Code _____

All correspondence will be sent to the above address, including examination results

Office Telephone _____ Home Telephone _____

Fax _____ E-mail _____

Current License (Please include a copy of your current state license registration to practice dentistry or certificate)

License or Certificate # _____ State/Country _____ Expiration Date _____

Have you ever had a license to practice dentistry/medicine suspended or limited? Yes _____ No _____
If yes, explain on a separate sheet

Dental Education

Institution	Location	From	To	Degree

Graduate/Other Education

Institution	Location	From	To	Degree

Board Certifications

Name of Board	Date of Certification	Date of Recertification

Diplomate Checklist

- Fully Completed Application
- Examination Fee of **\$795**
- Copy of Dental License with Expiration Date
- Letters of Recommendation from Two (2) Board-Certified Sleep Physicians (M.D., D.O., or Ph.D.)
- Ten (10) Hours at an Accredited Sleep Center/ Lab, Documented by a Physician (M.D., D.O., or Ph.D.)
- Five (5) Case Studies
- Spreadsheet of 15 distinct cases
- Proof of attendance/registration for 2 Annual AADSM Meetings

International Checklist

- Fully Completed Application
- Examination Fee of **\$795**
- Copy of Certificate with Expiration Date
- Letters of Recommendation from Two (2) Sleep Physicians
- Ten (10) Hours at a Sleep Center/Lab, Documented by a Physician
- Five (5) Case Studies
- Spreadsheet of 15 distinct cases
- Proof of attendance/registration for 2 Annual AADSM Meetings

Fees

I am enclosing the examination fee. I understand that \$300 of this fee will be refunded if my application is rejected and \$300 will be refunded if notification of withdrawal is received by the ABDASM no later than April 1, 2011. I understand that refunds for late withdrawals will be made at the discretion of the ABDASM.

Authorization and Release

I hereby authorize the American Board of Dental Sleep Medicine to consult with the individuals I have named in my application or with whom I have otherwise been associated who may have information bearing on my qualifications to sit for the examination. I hereby release from liability all such individuals who provide information to the American Board of Dental Sleep Medicine, in good faith and without malice, concerning my professional training and competence, ethics, and other qualifications to sit for the examination.

Declaration

I hereby declare that all information contained within this application and all documentation submitted with or in support of the application are true. I understand and agree that misinterpretation of said facts will result in disqualification to sit for the examination or revocation of the certification obtained.

Signature _____ Date _____

Payment (please check one)

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- 
- Check (US Funds Only)
Payable to: ABDASM

Card Number _____ Exp. Date _____

Printed Name _____ V-Code _____

Signature _____ Date _____