*(date)*

I, *(name of board-certified sleep physician)*, have worked with (*name of dentist*) in our community for the past (*amount of time worked together*).

(*State the nature of the working relationship, including any relevant points regarding sleep breathing disorder treatment initiatives.)*

I fully recommend (*name of dentist*) to challenge the American Board of Dental Sleep Medicine Examination.

*(board-certified sleep physician’s signature)*

*(name of board-certified sleep physician in print)*

*(Name of certifying board of sleep physician)*