Credential Verification Request
American Board of General Dentistry-Board Certified

Date: ___________

Requesting Facility: ______________________________________

Address: ______________________________________

City: ______________________ State: _______ Zip: __________

Contact Person: ______________________________________

Telephone: ____________________________ Ext: _________

Email: *(required)* ______________________________________

List names to be verified **Last Name, First Name, Middle Initial**	**Signed Release Attached Yes or No?**	**ABGD Use Only**

Please enclose $20.00 per verification, per individual. *# of verifications:* _________

Check #: ___________ Charge: Please select one: Visa Mastercard""""""""Co gz

Name of Facility issuing Check or Charge: ______________________________________

Name as it appears on card: ____________________________ Exp Date: ___________________

Credit Card Billing address: ______________________________________

City: ____________________________________ State: __________ Zip: ____________

Credit Card #: ____ 3 Digit Code: _________

I authorize the charge of $ ___________. I affirm that the information I have provided in this form is correct and I authorize the American Board of General Dentistry to proceed with the above credit card charge.

Date: _______________

Print Name: ______________________________ Sign Name: _____________________________

Email Request form and Signed Release(s) to assistant@americanboardofgeneraldentistry.org

OR Mail Check with request & signed release to:''

American Board of General Dentistry

490 Indian Rocks Rd N, Suite A
Belleair Bluffs, FL 33770-2085

Phone: 561-809-5491 Email: assistant@americanboardofgeneraldentistry.org

NOTE: Verifications cannot be released over the phone.