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 Please Circle**	**ABGD Use Only**
	Yes/No	
	Yes/No	
	Yes/No	
	Yes/No	

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

☐ Check #: _____ ☐ Charge: Please circle one: Visa Mastercard Amex

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 AssistantABGD@Tampabay.rr.com

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 E-mail: AssistantABGD@tampabay.rr.com

NOTE: Verifications cannot be released over the phone.