



Texas State Board of Dental Examiners

333 Guadalupe, Tower 3, Suite 800
 Austin, Texas 78701-3942
 (512) 463-6400 Fax (512) 649-1658
 www.tsbde.texas.gov

**WALL LICENSE REPLACEMENT
 REQUEST FORM**

Instructions: Dentists and Hygienists should use this form to replace the decorative wall license issued at the time of initial licensure. The wall license bears the signatures of every member of the Texas State Board of Dental Examiners (TSBDE). The Affidavit of Destruction or Loss of Texas Dental/Dental Hygiene license must accompany this request. Mail this form along with your check or money order to the TSBDE address listed above. Please allow two weeks for processing. Check (✓) which license type you are requesting.

<input type="checkbox"/> Dentist (DDS)	Total Amount Due \$25.00
<input type="checkbox"/> Registered Dental Hygienist (RDH)	

Social Security #:		License Number:		
Current Information				
First Name		Middle Name		Last Name
Current Address:		City	State	Zip
Permanent Address:		City	State	Zip:
Work Address:		City	State	Zip
Preferred mailing address: (preferred address will be made available to the public)				
<input type="checkbox"/> Current		<input type="checkbox"/> Permanent		<input type="checkbox"/> Work
Daytime Phone #:		Email Address:		
*Pursuant to Sec. 59.001 of the Dental Practice Act, the social security number of an applicant for or holder of a license, certificate of registration, or other legal authorization issued by a licensing agency to practice in a specific occupation or profession that is provided to the licensing agency is confidential and not subject to disclosure under Chapter 552, Government Code.				

I understand that my new certificate will be mailed to the address designated as my preferred mailing address above. I am including the Affidavit of Destruction or Loss of Texas Dental/Dental Hygiene license with this request.

 Signature

 Date



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**AFFIDAVIT OF DESTRUCTION OR LOSS OF
TEXAS DENTAL/DENTAL HYGIENE LICENSE**

STATE OF _____ COUNTY OF _____

I, _____ of _____, _____, do
(Name) (City) (State)

Hereby furnish the following information for obtaining a replacement Texas dental/dental hygiene license.

Mailing Address: _____

(City) (State) (Zip Code)

School
Attended: _____

Year
Graduated: _____

TX License
Number: _____

Year
Issued: _____

The actual circumstances surrounding the destruction and/or loss of the above-described license, which was originally issued to me, the above-named licensee, are as follows:

All of the information is true and correct. I understand that I may only possess one dental or dental hygiene wall license. I further state that I am the identical person to whom the above license was issued; and, should the above described license ever be found, I will return it to the office of the Texas State Board of Dental Examiners.

Signature

Before me, the undersigned authority, personally appeared _____ known by me to be the person whose name is subscribed above, and who, after first being sworn by me, stated under oath that the above given statements are true and correct.

(Notary Public)
and for _____ County; State of _____.
My Commission Expires _____.