TEXAS STATE BOARD OF DENTAL EXAMINERS
333 Guadalupe, Tower 3, Suite 800
Austin, Texas 78701-3942
Phone: (512) 463-6400 / Fax: (512) 463-7452
Website: www.tsbde.texas.gov
E-Mail: info@tsbde.texas.gov

Certified Dental Technician Change Request Form

INSTRUCTIONS: The Dental Laboratory Owner or Manager should complete this application and mail to the Texas State Board of Dental Examiners (TSBDE) within 60 days of a change in Certified Dental Technician (CDT).

DENTAL LABORATORY INFORMATION

Lab Name: _____ **Texas Lab Registration #**: _____

Physical Address: _____ _____ _____ _____ _____
Street City State Country Zip Code

Lab Owner or Manager's Name: _____ **The person completing this application is the:** _____ **Owner** _____ **Manager**

Owner or Manager Telephone Number: (_____) _____ **Owner or Manager E-Mail Address**: _____

FORMER CERTIFIED DENTAL TECHNICIAN INFORMATION

What is the name of the former CDT of Record: _____

NEW CERTIFIED DENTAL TECHNICIAN INFORMATION

Name of New CDT of Record: _____

Mailing Address: _____ _____ _____ _____ _____
Street City State Country Zip Code

Telephone Number: (_____) _____ **E-Mail Address**: _____

CDT of Record:

Is the new CDT of Record serving as a CDT of Record for another Texas registered dental laboratory: _____ Yes _____ No

If yes, provide the Texas Dental Laboratory Registration Number(s): _____, _____.

ATTESTATION

I understand that Section 266 of the Dental Practice Act requires that in order to qualify for registration by the TSBDE, a commercial laboratory must employ a Certified Dental Technician, who must be on premises at least thirty (30) hours per week.

I understand that the TSBDE Rules and Regulations require that a CDT of Record must be on the premises a minimum of 30 hours per week for each Texas registered dental laboratory.

I understand that the CDT Credential of the CDT listed above is active and that this CDT is currently registered with the National Board of Certification (NBC) or other Board-recognized credentialing organization.

I understand that as the Lab Owner or Manager that I am required to notify the TSBDE within 60 days of a change of CDT is made.

All facts stated herein are true and correct to the best of my knowledge.

_____ _____
Date Signature of Dental Laboratory Owner or Manager

STATE OF _____

COUNTY OF _____

Before me, the undersigned authority, on this day personally appeared the applicant whose signature appears above and who being by me sworn upon oath says that all the facts, statements and answers contained in this application are true and correct.

Sworn and subscribed to before me, the said _____ this the _____ day

of _____, 20 _____, to certify which witness my hand and seal of office.

(Seal) _____
Signature of Notary Public