



Virginia Department of  
**Health Professions**  
Board of Dentistry

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## EMPLOYMENT VERIFICATION

(Optional Form)

(MUST BE COMPLETED BEFORE A NOTARY PUBLIC)

Name of Employing Dentist(s) or Agency: \_\_\_\_\_

Complete Mailing Address: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

"I, \_\_\_\_\_ D.D.S./D.M.D./agency representative,  
(Print name & Title of the Employing Dentist or Agency Representative)

certify that \_\_\_\_\_, was employed by me as a \_\_\_\_\_  
(Print Applicant/Employee Name) (Print Job Title)

from \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ to \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_, in the clinical, ethical and legal practice of a  
Month Day Year Month Day Year

\_\_\_\_\_  
(Job Title)

\_\_\_\_\_  
Dentist's/Agency Representative Signature

\_\_\_\_\_  
Date

State of \_\_\_\_\_

County/City of \_\_\_\_\_

Sworn and subscribed to, before me, this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_  
Day Month Year

My commission expires on \_\_\_\_\_  
Month Day Year

**SEAL/STAMP**

\_\_\_\_\_  
Signature of Notary Public

\_\_\_\_\_  
Print Name