

**NEW HAMPSHIRE  
Dental Residency Program  
Reporting Form**

RSA 317-A:20 Practice of Dentistry. –

“III. Nothing in this section shall prevent:

- (d) Graduates from an American Dental Association accredited school from practicing in an American Dental Association accredited residency program under the supervision of a dentist holding an active license issued by the board for the duration of the residency program.”

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**I. General Information**

A. Program Name: \_\_\_\_\_

B. ADA Accredited Sponsor:

Name: \_\_\_\_\_

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

C. Facility/facilities:

Name: \_\_\_\_\_ Address: \_\_\_\_\_

Name: \_\_\_\_\_ Address: \_\_\_\_\_

D. Date program initiated: \_\_\_\_\_

**II. Professional Staff**

A. Chairperson Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

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

B. Supervising Faculty Member(s):

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Address: \_\_\_\_\_ NH dental license #: \_\_\_\_\_

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Address: \_\_\_\_\_ NH dental license #: \_\_\_\_\_

**III. Residents**

A. Name: \_\_\_\_\_ DOB: \_\_\_\_\_

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

Duration of residency: \_\_\_\_\_ Degrees: \_\_\_\_\_

B. Name: \_\_\_\_\_ DOB: \_\_\_\_\_

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

Duration of residency: \_\_\_\_\_ Degrees: \_\_\_\_\_

C. Name: \_\_\_\_\_ DOB: \_\_\_\_\_

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

Duration of residency: \_\_\_\_\_ Degrees: \_\_\_\_\_

D. Name: \_\_\_\_\_ DOB: \_\_\_\_\_

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

Duration of residency: \_\_\_\_\_ Degrees: \_\_\_\_\_

**IV. Type of Residency (OMS, Pediatric, GP, etc.)**

\_\_\_\_\_

**V. Program Services provided:**

A. \_\_\_\_\_ B. \_\_\_\_\_

C. \_\_\_\_\_ D. \_\_\_\_\_

E. \_\_\_\_\_ F. \_\_\_\_\_

Please submit an updated report to the NH Board of Dental Examiners when the foregoing information in Sections I through V changes or yearly, whichever occurs first.

**Report submitted by:**

\_\_\_\_\_  
**Name/Position**

\_\_\_\_\_  
**Date**