



DOUGLAS A. DUCEY  
GOVERNOR

ARIZONA STATE VETERINARY MEDICAL EXAMINING BOARD  
1740 W. ADAMS ST., SUITE 4600, PHOENIX, ARIZONA 85007  
PHONE: 602-364-1PET(1738) ♦ FAX: 602-364-1039  
[VETBOARD.AZ.GOV](http://VETBOARD.AZ.GOV)

VICTORIA WHITMORE, EXECUTIVE DIRECTOR

**EQUINE DENTISTRY INFORMATION**

**Alternative Format for Submitting Application:** An individual with a disability who, as a result of the disability, requires this registration to be in an alternative format may contact the Board’s Americans with Disability coordinator at (602) 364-1738, or Voice Relay Service (800) 842-4681 or TTY at (800) 367-8939 to make their needs known.

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

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

Mailing Address (if different): \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_ Fax Number: \_\_\_\_\_

**PLEASE COMPLETE ALL OF THE FOLLOWING**

- I am certified by: \_\_\_\_\_ Effective Date: \_\_\_\_\_
  - Continuing Certification Date: \_\_\_\_\_
  - Provide proof of current certification from the International Association of Equine Dentistry or the Academy of Equine Dentistry.
- Attach a written statement signed by each supervising licensed veterinarian that the certified equine dental practitioner will be under the general or direct supervision of the licensed veterinarian: A.R.S. §32-2231 (B)(3).
- I will be supervised by the following Arizona licensed veterinarian(s): (If additional space is required, please attach a separate sheet of paper.)

Veterinarian’s Name: \_\_\_\_\_

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

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

Clinic Phone: \_\_\_\_\_

Veterinarian’s Name: \_\_\_\_\_

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

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

Clinic Phone: \_\_\_\_\_

Veterinarian’s Name: \_\_\_\_\_

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

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

Clinic Phone: \_\_\_\_\_

I hereby declare under penalty of perjury under the laws of the state of Arizona that the answers I have given are true and correct to the best of my knowledge.

\_\_\_\_\_/\_\_\_\_\_  
Signature Date