



CANNON BUILDING  
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STATE OF DELAWARE  
**BOARD OF DENTISTRY AND DENTAL HYGIENE**

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EMAIL: [customerservice.dpr@delaware.gov](mailto:customerservice.dpr@delaware.gov)

### STATEMENT OF SUPERVISION FEDERALLY QUALIFIED HEALTH CENTER (FQHC)

Name of Applicant: \_\_\_\_\_ Enter your Application ID: \_\_\_\_\_

#### FEDERALLY QUALIFIED HEALTH CENTER DIRECTOR The FQHC director completes this section in the presence of a notary public.

Printed Name of FQHC Director: \_\_\_\_\_

FQHC Director's Delaware License No: \_\_\_\_\_

- I verify that the above-named applicant is contracted to practice at:  
Name of Institution: \_\_\_\_\_ Start Date (month/day/year): \_\_\_\_\_
- I verify that the applicant will be practicing under the general supervision of a Delaware-licensed dentist.
- I verify that the applicant's credentials have been reviewed and approved.
- If the supervising dentist becomes unable or unavailable to provide direction to the applicant, I understand that this FQHC must contract with another Delaware-licensed dentist to provide direction and that I must submit a new *Statement of Supervision* form.
- I will report immediately if the contract between the named applicant and this FQHC terminates.

**Signature of FQHC Director:** \_\_\_\_\_ Date: \_\_\_\_\_

State of \_\_\_\_\_, County of \_\_\_\_\_

Sworn and subscribed before me this \_\_\_\_\_ day of \_\_\_\_\_ 2 \_\_\_\_\_

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

SEAL

My Commission Expires: \_\_\_\_\_

#### SUPERVISING DENTIST The applicant's supervising dentist completes this section.

Printed Name of Supervising Dentist: \_\_\_\_\_

Delaware License No: G1 - \_\_\_\_\_

- I accept responsibility for the applicant's practice of dentistry in this FQHC.
- I will notify the Board if my supervision of the above named applicant terminates.

**Signature of Supervising Dentist:** \_\_\_\_\_ Date: \_\_\_\_\_

**Mail the completed, signed and notarized form to the attention of the Board of Dentistry and Dental Hygiene at the address above.**