

CERTIFICATE OF COMPLETION

INDIANA STATE BOARD OF DENTISTRY
PROFESSIONAL LICENSING AGENCY
402 WEST WASHINGTON STREET, ROOM W072
INDIANAPOLIS, INDIANA 46204
(317) 234-2054
Pla8@pla.IN.gov
www.pla.IN.gov

DENTIST _____ DENTAL HYGIENIST _____

I hereby certify that _____ was admitted to the
(Name)

_____ located in _____
(School) (City and State)

on _____; and will graduate/graduated on _____; and
(Date of Admission) (Date of Graduation)

will receive/received the degree of D.D.S. _____, D.M.D. _____, or a degree in Dental
Hygiene _____.

SIGNATURE OF DEAN

SIGNATURE OF REGISTRAR

PRINTED SIGNATURE OF DEAN

PRINTED SIGNATURE OF REGISTRAR

DATE: _____

DATE: _____

**SCHOOL SEAL MUST BE IMPRINTED ON THIS FORM OR IT WILL NOT BE
ACCEPTED**

APPLICANT: This Certificate of Completion will be accepted in lieu of a notarized copy of your diploma only if it is signed by both the Dean and Registrar of your professional school. A certificate of Completion will not be accepted in lieu of a transcript under any circumstances.

DEAN/REGISTRAR: Certificates of Completion may not be sent to the Professional Licensing Agency until the applicant has completed all requirements for graduation.