



AUGUSTA UNIVERSITY

**DENTAL COLLEGE  
OF GEORGIA**

The Dental College of Georgia  
Dept. of Oral Health & Diagnostic Sciences  
1430 John Wesley Gilbert Drive  
Augusta, GA 30912  
Office (706) 721-2607  
Fax (706) 721-4937

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## DENTAL CLEARANCE LETTER

DATE: \_\_\_\_\_

Re: \_\_\_\_\_ DOB: \_\_\_\_\_

To Whom It May Concern:

You have requested that the above candidate provide you with their current dental status.

Date of last dental exam: \_\_\_\_\_

\_\_\_ Applicant has no current dental problems that need treatment at this time.

\_\_\_ Applicant has dental conditions that have not been treated.

Additional Information: \_\_\_\_\_

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\_\_\_\_\_  
Supervising Dentist's Signature

\_\_\_\_\_  
Dental Student's Signature

\_\_\_\_\_  
Supervising Dentist's Name

\_\_\_\_\_  
Dental Student's Name and Number