



Maine Center for Disease Control and Prevention

An Office of the Department of Health and Human Services

Paul R. LePage, Governor

Mary C. Mayhew, Commissioner

Department of Health and Human Services
Maine Center for Disease Control and Prevention
286 Water Street
11 State House Station
Augusta, Maine 04333-0011
Tel.: (207) 287-8016; Fax: (207) 287-9058
TTY Users: Dial 711 (Maine Relay)

Oral Health Program
Tel. (207) 287-2361
Fax (207) 287-7213

DENTAL CARE ACCESS CREDIT PROGRAM

Instructions: FAX the completed and signed form to the Maine Oral Health Program at (207) 287-7213. Send the form with an original signature in blue ink to: Director, Oral Health Program, ME CDC, 11 State House Station, 286 Water Street, 5th floor, Augusta, ME 04333-0011. Please type or print legibly.

Section I. Name: (Your legal name as used for dental licensure, federal and state tax purposes)

Mailing address: (in Maine)

Telephone: (City/town, State) (Zip)

E-mail address:

Section II. Date initially licensed to practice dentistry in Maine by the Maine Board of Dental Examiners: License Number:

NOTE: Date of licensure must be January 1, 2009 or later in order to be eligible for this Program.

Section III. I attest that after January 1, 2009, I (check one) and provide date (mm/dd/yyyy):

- Joined an existing dental practice in a dental health professional shortage area on
Purchased an existing dental practice in a dental health professional shortage area on
Established a new dental practice in a dental health professional shortage area on

Name of practice:

Practice Address: (Street address, City/town/ME, zip)

Section IV. By signing this form, I also attest that:

- I agree that I will practice in a designated dental health professional shortage area for five years; and
I understand that the Dental Care Access Credit Program is available to me only for those years for which I am certified as eligible.

(Signature) (Your legal name as above) (Date)

If you are employed in the practice, provide the following information so that your employment can be verified:

Contact name: Title:

Contact telephone number: Email:

Notice to Applicant: If certified, you are required to report to the Oral Health Program if your practice location changes in order to affirm that you continue to practice in a designated dental health professional shortage area, and keep your personal contact information up to date.