



National Board for Certification in
Dental Laboratory Technology



Internal Use Only

ID Number: _____
Approved By: _____ Site Number: _____
Exam: _____ Exam Date: _____

ADDITIONAL CDT SPECIALTY APPLICATION

I. Applicant's Information

Applicant's Name: _____ CDT Number: _____
Mailing Address: _____ (No PO Boxes - This is where molds will be sent)
City: _____ State: _____ Zip: _____
Home Phone: _____ Business Phone: _____
Email: _____ Current Specialties: _____

II. Exam Selection

Specialty Exam

Please complete the below section if you are utilizing computer-based testing (CBT):

- Complete Dentures Partial Dentures Crown & Bridge Ceramics Orthodontics Implants
- January Testing Window (12/20 deadline)
- February Testing Window (1/20 deadline)
- March Testing Window (2/20 deadline)
- April Testing Window (3/20 deadline)
- May Testing Window (4/20 deadline)
- June Testing Window (5/20 deadline)
- July Testing Window (6/20 deadline)
- August Testing Window (7/20 deadline)
- September Testing Window (8/20 deadline)
- October Testing Window (9/20 deadline)
- November Testing Window (10/20 deadline)
- December Testing Window (11/20 deadline)

Candidates must schedule and complete their examination within 30 days once they have been approved by NBC to test. Testing windows run from the first day of each month through the last day of each month. Registration deadlines are the 20th of the month prior to your desired testing window.

Please complete the below section if you are utilizing paper-based testing (PBT):

- Complete Dentures Partial Dentures Crown & Bridge Ceramics Orthodontics Implants
- City: _____ Date: _____

Practical Exam

- Complete Dentures Partial Dentures Crown & Bridge Ceramics Orthodontics Implants
- City: _____ Date: _____

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III. Eligibility and Affidavit

I have read and understand the CDT examination handbook and application. I agree to submit to testing for certification according to the requirements and procedures specified by the NBC.

I agree to indemnify and hold harmless the NBC, its Trustees, officers, employees and agents, and the institution where the CDT examination is administered from any and all liability for injury or damages suffered by me, or which I might cause to others, during the course of taking my examination.

I agree to abide by the laws and regulations which govern the practice of dentistry and the practice of providing dental laboratory technology services, restorations and services to the dental profession.

I affirm that all statements made by me in this application are true and correct to the best of my knowledge. I understand that any misinterpretation of facts made in this application for testing or in future applications to the NBC for certification testing or renewal, or in my personal claim to certification (use of CDT designation and logo), may be found cause for suspension or denial of certification or eligibility for certification testing.

I understand that NBC operates its examinations with specific procedures that ensure the integrity of the examination process. I understand that if I fail to follow NBC's policies and procedures that my examination results will not be valid and I would be required to retest at my own expense.

I understand that this application will be considered an addendum to the original application submitted.

Applicant's Signature: _____ Date: _____

IV. Payment

- Written Specialty Exam (CBT) – \$245
- Written Specialty Exam (PBT) – \$220
- Practical Exam – \$495

TOTAL \$ _____

Candidates who require their Practical exam molds to be shipped outside of the US will be responsible for covering the costs of international shipping. NBC will provide you with your total after determining the shipping costs before proceeding with payment.

Late fees apply for any exam applications submitted after the published deadline. Late fees are \$25.00 for each written exams and \$50.00 for practical exams.

- Enclosed is Check# _____ in the amount of \$ _____ payable to the NBC.
- Please charge my credit card VISA MC AMEX Amount \$ _____
Credit Card #: _____ Expiration Date: _____
Security Code: _____ **The 3 digit number on the back of your card. AMEX cards only, the 4 digit number on the front of your card.*
Cardholder Name: _____ Signature: _____
Billing Address: _____
City: _____ State: _____ Zip: _____

If you have not signed your application or enclosed the required fees, your application will not be processed.