AMERICAN BOARD OF PEDIATRIC DENTISTRY

Examination Results Appeal Form

Date: ____

Name of Candidate: ____

Address: ____

Office Phone Number (with area code): __________________________

Email: ____

Identify the decision being appealed (circle):

Condition of Appeal (select condition that applies)

- Procedural error or difficulties in administration of an examination
- Equipment or facility failure

Provide your reasons for an appeal in a brief outline format:

Appeal of Examination Results fee: $500

Examination Results Appeal Form is used to appeal an examination decision and must be filed with the American Board of Pediatric Dentistry within 30 days of the date on the notification letter. Appeal Form must be submitted with appropriate fee.

I attest to the accuracy of the above information and request that an appeals procedure be initiated by the American Board of Pediatric Dentistry for the purpose of investigating the decision cited above. I understand and agree that members of the Appeals Committee or any persons testifying before it or furnishing evidence to it would have absolute civil immunity to damages for any acts, information, or recommendations so long as made or given in good faith and without malice.

Signature of Candidate:

Return form and fee to:

American Board of Pediatric Dentistry 5034 Thoroughbred Lane, Ste A Brentwood, TN 37027

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