**Physician recommendation**

A requirement for the Fellow of Dental Sleep Medicine certification program is a recommendation from a sleep physician who has worked with the candidate. If you are happy to provide a recommendation, please answer the following questions and sign this form.

What is the nature of your relationship with the candidate? How many years have you known them?

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Have you worked with the dentist previously or referred cases to them?

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Have they demonstrated an understanding of sleep medicine? Why do you recommend this certification for them?

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I recommend the dentist named below for the Fellow of Dental Sleep Medicine certification.

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(Name of recommended dentist)

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(Name of sleep physician)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Sleep physician’s signature) Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_