UMC UNIVERSITY MEDICAL CENTER
TRANSPLANT CENTER

Dental Clearance

NAME: _____ DOB: _____has completed his/her dental examination. He/she does not have any active infection that would prevent him/her from having a kidney transplant and taking immunosuppressive medication.

Please circle one: Cleared / Not Cleared

FROM: _____ _____
DDS SIGNATURE DATE

- PRINT DDS FULL NAME_____
- FACILITY NAME _____
- PHONE NUMBER _____

Please fax complete form to: 702-383-1876

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Phone: (702) 383-2224
Fax: (702) 383-1876