Dental Clearance

TO: RENAL TRANSPLANT PROGRAM
UNIVERSITY MEDICAL CENTER
1800 W. CHARLESTON BLVD
LAS VEGAS, NV 89106

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

Please circle one: Cleared / Not Cleared

State reason if not cleared:

FROM: _____ _____
DDS SIGNATURE DATE

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