



North Dakota State Board of Dental Examiners

P.O. Box 7246 • Bismarck, North Dakota 58507-7246
ndsbd@aptnd.com www.nddentalboard.org

Continuing Education Registry Reporting Form

Dentist _____
Hygienist _____
Assistant _____

Please check here to indicate a name or address change.

Name: _____ Lic # or _____
Last First MI Maiden Regis. # _____

Address: _____
Street or Box Number City State Zip

Home Phone _____ Work Phone _____ Email _____

Please note:

1. This form may be duplicated as necessary.
2. C.E. requirements are as follows:

Dentists: 32 credits per 2 year cycle: 2 hours of infection control and CPR per 24 months, maximum non-clinical hours: 6, and maximum home study: 10

Hygienists: 16 credits per 2 year cycle, 2 hours infection control and CPR per 24 months, maximum non-clinical hours: 3, and maximum home study: 5

Registered/Qualified Assistants: 8 credits per calendar year, 2 hours of infection control and CPR per prior 24 months, maximum non-clinical hours: 3, and maximum home study: 2

3. **Dentists & Hygienists ONLY: DO NOT THROW AWAY YOUR CE CERTIFICATES!** After all the renewal applications have been received, you may be selected for a random audit of your continuing education. Please keep materials that are pertinent to your CE coursework as "proof" in the event of an audit. Examples of items to save are receipts, registration materials, certificates, or cancelled checks.

4. Please fill out this form completely, sign, date and mail to:
**NDSBDE Registry
P.O. Box 7246
Bismarck, ND 58507-7246**

I certify that the information provided is true and correct. I understand that filing of false information is a violation of North Dakota state law and subject to penalty.

Signature of Participant _____

_____ Date

You must include course title, course date and hours of instruction in order to receive credit!

Course Title: _____ Home Study? Yes No

Clinician/Speaker: _____ Course Date(s) _____

Sponsor: _____ Hours of Instruction: _____

Location: _____ Course Clinical _____
Content Non-Clinical _____
Infection Control _____

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Course Title: _____

Clinician/Speaker: _____

Sponsor: _____

Location: _____

Home Study? Yes No

Course Date(s) _____

Hours of Instruction: _____

Course Content Clinical _____
 Non-Clinical _____
 Infection Control _____

Course Title: _____

Clinician/Speaker: _____

Sponsor: _____

Location: _____

Home Study? Yes No

Course Date(s) _____

Hours of Instruction: _____

Course Content Clinical _____
 Non-Clinical _____
 Infection Control _____

Course Title: _____

Clinician/Speaker: _____

Sponsor: _____

Location: _____

Home Study? Yes No

Course Date(s) _____

Hours of Instruction: _____

Course Content Clinical _____
 Non-Clinical _____
 Infection Control _____

Course Title: _____

Clinician/Speaker: _____

Sponsor: _____

Location: _____

Home Study? Yes No

Course Date(s) _____

Hours of Instruction: _____

Course Content Clinical _____
 Non-Clinical _____
 Infection Control _____

Course Title: _____

Clinician/Speaker: _____

Sponsor: _____

Location: _____

Home Study? Yes No

Course Date(s) _____

Hours of Instruction: _____

Course Content Clinical _____
 Non-Clinical _____
 Infection Control _____