



# North Dakota State Board of Dental Examiners

PO Box 7246, Bismarck, ND 58502 • Phone 701-258-8600 • Fax 701-224-9824

Web [www.nddentalboard.org](http://www.nddentalboard.org) • Email [ndsbd@aptnd.com](mailto:ndsbd@aptnd.com)

## Application for Initial Registration of Dental Assistant

Initial registration fee - \$130.00

OFFICE USE ONLY - Postmark Date: \_\_\_\_\_ Date Received \_\_\_\_\_ Amount \_\_\_\_\_ Check # \_\_\_\_\_

North Dakota Administrative Rule 20-03-01-05 requires that any individual engaged in performing expanded duties in the practice of dental assisting must register with the Board of Dental Examiners by submitting application accompanied by a fee determined by the Board.

### TYPE OR PRINT LEGIBLY

Full Name (First, Middle, Last, Maiden)	Current Registration Number
Social Security Number	Date of Birth
Home Address	Home Phone
City State	Zip Code + 4
Email address	
Office/Employer Name	Office Address
City State	Zip Code + 4
Office Phone Number	Office Fax Number

### **ALL APPLICANTS MUST ANSWER THE FOLLOWING QUESTIONS OR THE FORM WILL BE RETURNED.**

- Have you been named as a defendant or respondent in any malpractice proceeding within the last 12 months?  
Yes \_\_\_\_\_ (Attach explanation) No \_\_\_\_\_
- Have you been charged with or convicted of any crime, felony, or misdemeanor within the last 12 months?  
Yes \_\_\_\_\_ (Attach explanation) No \_\_\_\_\_
- Have you been cited for operating a motor vehicle while under the influence of drugs or alcohol within the past 12 months?  
Yes \_\_\_\_\_ (Attach explanation) No \_\_\_\_\_
- Date of your last infection control course. (Must be within 24 months)  
Attach documentation if not on transcript or with DANB exam. \_\_\_\_\_  
Month/Year
- Date of your last CPR course. (Must be within the last 24 months)  
Online CPR coursework is not acceptable for this requirement.  
Attach a copy of your CPR card \_\_\_\_\_  
Month/Year

6. Graduates from an ADA accredited dental assisting program are eligible to apply pit and fissure sealants. Dental assistants who have passed a Board authorized training course or are office trained and have successfully challenged the DANB exam, must submit documentation of this coursework. Documentation may include class syllabus, course outline or certificate of training from course sponsors or instructors. Attach any supporting documentation.

\_\_\_\_\_

Name and location of course Month/Year

7. Before monitoring nitrous oxide inhalation analgesia, office trained dental assistants who have successfully taken the DANB exam or dental assistants who have passed a Board authorized training course must show proof of nitrous oxide training. Documentation may include class syllabus, course outline or certificate of training from course sponsors or instructors. Attach any supporting documentation.

\_\_\_\_\_

Name and location of course Month/Year

8. Name of Board approved or ADA accredited program you graduated from. Attach copy of the transcript.

\_\_\_\_\_

Name and location of program Month/Year

**OR**

9. Are you an office-trained dental assistant? Yes \_\_\_\_\_ No \_\_\_\_\_

Date DANB examination was passed. Attach copy of certificate or test scores. \_\_\_\_\_  
Month/Year

**11. QUALIFIED ASSISTANTS only:**

Date of DANB RHS (Radiation Health and Safety) Exam: \_\_\_\_\_  
Month/Year

Date of DANB ICE (Infection Control) Exam: \_\_\_\_\_  
Month/Year

(Attach documentation for both exams)

**I certify that the information provided is true and correct. I understand that it is a violation of NDCC 43-28-17 to make any false or untrue statement in the application. Making false or untrue statements may lead to loss of registration.**

Signature of Assistant: \_\_\_\_\_ Date: \_\_\_\_\_

**Application Fee: \$130.00 (The renewal fee is non-refundable.)  
 Make check payable to NDSBDE. Incomplete applications will not be processed.**