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 • Email info@nddentalboard.org

2021-2022 APPLICATION
RESTORATIVE FUNCTIONS PERMIT | RESTORATIVE FUNCTIONS RENEWAL

OFFICE USE ONLY - Postmark Date:

The North Dakota Board of Dental Examiners may issue or renew a permit authorizing a registered dental assistant (RDA) or a registered dental hygienist (RDH) to provide restorative functions under the direct supervision of a dentist. An RDH or RDA may perform the placement and finishing of direct alloy or direct composite restorations, under the direct supervision of a licensed dentist, after the supervising dentist has prepared the dentition for restoration. The restorative functions shall only be performed after the patient has given informed consent for the placement of the restoration by a restorative functions registered dental assistant or registered dental hygienist. Before the patient is released, the final restorations shall be checked and documented by the supervising dentist. There is no fee associated with this application.

The permit is subject to renewal at the time of license/registration renewal. An individual may not provide restorative functions duties until the Board approves the application. If the restorative functions permit renewal application is not postmarked on or before December 31st (of odd numbered years for the RDH; even numbered years for the RDA), the permit expires. **Note:** The mailing and email addresses you provide will be your addresses of record. It is your responsibility to maintain current contact information with the Board.

IDENTIFYING INFORMATION			
PRINT Full Name (First, Middle, Last, Maiden)		Email Address	☐ RDA ☐ RDH
Social Security Number	Date of Birth	ND RDA Registration or ND RDH License Number	
Home Address		Home Phone Cell phone	
City State		Zip Code + 4	
Office/Employer Name			
Office/Employer County		Office Address	
City State		Zip Code + 4	
Office Phone Number		Office Fax Number	

VERIFICATION OF EDUCATION | TRAINING | COMPETENCY EXAMINATION

☐ **I WISH TO SUBMIT INITIAL APPLICATION FOR THE RESTORATIVE FUNCTIONS PERMIT** (check one of the following):

☐ The applicant successfully completed a Board-approved curriculum from a program accredited by the Commission on Dental Accreditation (CODA) of the American Dental Association or other board-approved course and successfully passed the Western Regional Examining Board's restorative examination or other equivalent examinations approved by the board within the last five years; OR

☐ The applicant successfully completed a Board-approved course and successfully passed the Western Regional Examining Board's (WREB) restorative examination or other Board approved examination over five years from the date of application and provides evidence from another state or jurisdiction where the applicant legally is or was authorized to perform restorative functions and certification from the supervising dentist of successful completion of at least twenty-five restorative procedures within the previous five years from the date of application.

SUBMIT EVIDENCE OF THE FOLLOWING (photocopies only):

- ✓ Current and valid certification for Health Care Provider Basic Life Support, or Advanced Cardiac Life Support or Pediatric Advanced Life Support; and
- ✓ Evidence of successfully completing a Board approved curriculum from a program accredited by CODA;
- ✓ Evidence of successfully passing the WREB or other Board approved clinical competency examination;
- ✓ Evidence of successfully passing restorative function component of the DANB certified restorative functions dental assistant certification examination or other Board-approved competency written examination;
- ✓ An applicant who has taken WREB over five years from application date, must provide a letter of endorsement and verification of competently performed restorative procedures.

☐ **I wish to RENEW the RESTORATIVE FUNCTIONS PERMIT** and I am submitting with this application a photocopy of current Health Care Provider Basic Life Support (BLS) or Advanced Cardiac Life Support (ACLS) or Pediatric Advanced Life Support (PALS) and I am submitting 2 hours of continuing education related to the permit renewal.

DISCLOSURE | Please respond to all questions. If you answer "YES" to any question, please attach a written explanation. IN SUPPORT OF YOUR EXPLANATION, THE FINAL DOCUMENTS OR ORDERS FROM THE ISSUING STATES, COURTS, AND/OR AGENCIES MUST BE SUBMITTED ALONG WITH THIS APPLICATION.

1. Have you been named as a defendant or respondent in any malpractice proceeding within the last 24 months?	**YES**	**NO**
2. Have you ever been charged with or convicted of any crime, felony or misdemeanor other than a minor traffic offense within the last 24 months?	**YES**	**NO**
Note: If you answered "yes" to questions (1) or (2) you must send certified copies of all court documents related to your criminal history with your application. If you do not provide the documents, your application is incomplete and will not be considered. A criminal history may not automatically bar you from obtaining a credential. However, failure to report criminal history may result in extra cost to you and the application may be delayed or denied.		
3. Have you ever been cited for operating a motor vehicle while under the influence of drugs or alcohol within the past 24 months?	**YES**	**NO**
"Illegal use of controlled substances" means the use of controlled substances obtained illegally (e.g., meth, or cocaine) as well as the use of controlled substances that are not obtained pursuant to a valid prescription or not taken in accordance with the directions of a licensed health care practitioner.		
If you answered "yes" to question (3) the Board will require copy of evaluation and recommendations for treatment if any were issued; a copy of the criminal charges, reported offense, police report and judgment and disposition of criminal complaint; disposition of the offense, final disposition, any orders or any actions pending. Please send your information directly to the Board.		
4. Are you currently engaged or have you engaged in the last 24 months in the illegal use of controlled substances? If 'yes', are you currently participating in a supervised rehabilitation program or professional assistance program that monitors you in order to assure that you are not engaged in the illegal use of controlled substances?	**YES**	**NO**
5. Have you ever held or applied for a license or certificate in any state, country, or province has or was it ever been denied, reprimanded, suspended, restricted, revoked, otherwise disciplined, or voluntarily surrendered under threat of investigation or disciplinary action?	**YES**	**NO**
6. If you have ever held a license or certificate in any health care profession, has it ever been reprimanded, suspended, restricted, revoked, otherwise disciplined, or voluntarily surrendered under threat of investigation or disciplinary action?	**YES**	**NO**

I fully understand I will be subject to the penalties imposed pursuant to NDCC § 43-28 if I provide duties beyond my scope of training and education beyond the duties specified in Chapter 20-03 and Chapter 20-04. I acknowledge that while my permit is active, I must renew the permit biennially, and keep my address current with the Board in accordance with NDCC § 43-28-23. I further attest 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. **I understand that should I provide any false information, my RDA registration may be suspended or revoked.**

Signature of registered dental assistant: _____ Date: ____/_____/20_____

Mail this form to: NDBDE
PO Box 7246
Bismarck, ND 58507-7246