North Dakota Board of Dental Examiners

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Web www.nddentalboard.org • Email info@nddentalboard.org

Initial Registration or Reinstatement Application
Qualified Dental Assistant-Limited Radiology Registrant

OFFICE USE ONLY - Postmark Date: _____ **Date Received:** _____ **Fee: ($0.00 at Present)**

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 an application to the Board. Please type or print clearly. Follow the instructions provided. It is the responsibility of the applicant to submit all required supporting documents for registration as a Qualified Dental Assistant-Limited Radiology Registrant (QDA-LRR). Failure to do so may result in a delay in processing your application. **Note:** The mailing and email addresses you provide will be your addresses of record. It is your lawful responsibility to maintain current contact information with the Board.

IDENTIFYING INFORMATION			
Military Status: Are you are a member of OR a spouse of a member of the armed forces of the United States or a reserve component of the armed forces of the United States? ☐ YES ☐ NO (If yes, please provide proof of military/spouse status, such as military orders or current base ID.)			
Full Name (First, Middle, Last, Maiden)			
Social Security Number	Date of Birth	Email Address	
Home Address		Home Phone	Cell phone
City	State	Zip Code + 4	
Employer Name		Employer County	
Office Address	City	State	Zip Code + 4
Office Phone Number	Office Fax Number		
HAVE YOU EVER BEEN REGISTERED AS A DENTAL ASSISTANT IN THIS STATE? ☐ YES ☐ NO			

DISCLOSURE		
1. Have you ever been found in any proceeding to have violated any state or federal law or rule regulating the practice of a health care profession? If "yes", please attach an explanation and provide copies of all judgments, decisions, and agreements?	**YES**	**NO**
2. Have you ever had any license, certificate, registration or other privilege to practice a health care profession denied, revoked, suspended, or restricted by a state, federal, or foreign authority?	**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 charged with or convicted of any crime, felony, or misdemeanor?	**YES**	**NO**
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. Have you ever been named in any civil suit or suffered any civil judgment for incompetence, negligence or malpractice in connection with the practice of a health care profession?	**YES**	**NO**
If you answered "yes" to question 4 and 5, you must explain the nature of the prosecution and/or charge(s). You must include the jurisdiction that is investigating and/or prosecuting the charges. This includes any city, county, state, federal or tribal jurisdiction. If charging documents have been filed with a court, you must provide copies of those documents. If you do not provide the documents, your application is incomplete and will not be considered.		

5. Have you ever been found in any civil, administrative or criminal proceeding to have: a. Possessed, used, or distributed controlled substances or prescription drugs in any way other than for legitimate or therapeutic purposes?	**YES**	**NO**
b. Diverted controlled substances or legend drugs?	**YES**	**NO**
c. Violated any drug law?	**YES**	**NO**
d. Prescribed controlled substances for yourself?	**YES**	**NO**
e. Been cited for operating a motor vehicle while under the influence of drugs or alcohol?	**YES**	**NO**
6. Do you currently use chemical substance(s) in any way which impair or limit your ability to practice your profession with reasonable skill and safety? If yes, please attach explanation.	**YES**	**NO**
7. Are you now subject to criminal prosecution or pending charges of a crime in any state or jurisdiction?	**YES**	**NO**
8. Date of last infection control course. [Must be within 24 months] ____/____/____ Attach documentation.		
9. Submit a copy of CPR certification taken within 24 months of application. Online CPR coursework must have hands-on component.		

TRAINING AND EDUCATION - CHECK ONE of the following:

☐ **REINSTATEMENT OF REGISTRATION: Dental assistants reinstating a previously held registration must submit proof of continuing education from the previous 24 months pursuant to Administrative Rule 20-03-01-06.**

RADIATION HEALTH AND SAFETY COURSE COMPLETION

☐ **CODA ACCREDITED DENTAL ASSISTING PROGRAM** Name of program accredited by the Commission on Dental Accreditation (CODA) you graduated from

_____

Name and location of program – attach documentation Month/Year

☐ **DANB Radiation Health and Safety Program**

_____ ____/____

Location of clinical portion of program – attach documentation Month/Year

☐ **DA PREP Radiation Health and Safety Program**

_____ ____/____

Location of clinical portion of program – attach documentation Month/Year

☐ **OTHER Radiation Health and Safety Program**

_____ ____/____

Name and location of clinical portion of program – attach documentation Month/Year

ALL APPLICANTS MUST SUBMIT PROOF OF CURRENT CPR OR BLS CERTIFICATION.

I certify I have completed the requirements of initial application including all continuing education requirements, cardiopulmonary resuscitation, and infection control education. I understand I must maintain a current cardiopulmonary resuscitation certificate. I understand that should I provide any false information, my registration may be denied, or if issued, suspended or revoked.

Signature of dental assistant: _____ **Date:** ____/____/____

Mail application and supporting materials to: NDSBDE, PO Box 7246, Bismarck, ND 58507-7246