



# North Dakota State Board of Dental Examiners

PO Box 7246, Bismarck, ND 58507-7246 • Phone 701-258-8600

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

## Application for Qualified Dental Assistant

### Applicable Laws for Qualified Dental Assistant

- N.D.A.C. 20-03-01-05(2) explains the criteria for registering as a Qualified Dental Assistant and N.D.A.C. 20-03-01-01(4) explains the duties a Qualified Dental Assistant may perform, and the related level of supervision.
- N.D.A.C. 20-03-01-06 explains that this registration must be renewed biennially, and lists the related continuing education requirements.
- Applicants must thoroughly review N.D.A.C. [20-03-01.pdf](#), and be able to demonstrate an understanding of the laws cited above.

### Application

- **Do not submit incomplete applications. Applications are not complete until all forms and associated materials are received, including fee payment and confirmation that the applicant passed any required exams. Submitting incomplete applications delays the Board's decision on the application.**
- For those completing hardcopy applications:
  - Type or print clearly; print single-sided, and do not staple any submissions.
  - Attach additional sheets of paper as needed. Added sheets must refer to your application.
  - Email completed application and materials to [info@nddentalboard.org](mailto:info@nddentalboard.org), or mail them to the address above.

### North Dakota Jurisprudence Examination

- Once an application is received, applicants will be given permission to take the jurisprudence examination.
- The jurisprudence examination is provided online and at no cost, and earns the applicant 2 CE hours.

### Accepted Forms of Payment for Fees

- Check (personal/cashiers).
- Online payment through debit or credit card (once online payments are available on the Board's website).
- Unacceptable forms of payment include cash, money orders, and American Express cards.

### Contact Information and Names

- Current and complete contact information is required for all applicants. Email addresses must be included on the application and will be used by the Board related to the processing of your application.
- Submit documentation of any legal name change.
- If you become licensure or registered, you must update the Board with any change of name, address, email address, phone, employers, and other contact information. Failure to do so can result in you not receiving critical information in a timely manner and may result in discipline.

### Disclosure Questions

- If you have had a criminal conviction, please submit:
  - A personal statement detailing the events leading up to and following the conviction.
  - Criminal judgments and sentencing orders.
- A copy of the arresting officer's report, if available.



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**Non-refundable Fee: \$160.00**

OFFICE USE ONLY - Postmarked: \_\_\_\_\_ Received: \_\_\_\_\_ Amount: \_\_\_\_\_ Payment Type: Check # \_\_\_\_\_ Online # \_\_\_\_\_

General Contact Information			
Legal First Name	Legal Middle Name	Legal Last Name	Today's Date (mm/dd/yyyy)
Other Legal Names Previously Used (include proof of legal name changes and indicate if exam scores use these names)			
Home Street Address		Apt. Number	Home City, State, Zip (4+ digits)
Phone Numbers (c) (h) (w)	Employer's Name, Address, Unit Number		Employer's City, State, Zip (4+ digits)
Personal Email Address ( <b>required</b> )		Business/Employment Email Address	
Gender Male <input type="checkbox"/> Female <input type="checkbox"/> X <input type="checkbox"/>		Date of Birth (mm/dd/yyyy)	Social Security Number
<p><b>Military Status:</b> Are you a member of the armed forces of the United States or a reserve component of the armed forces of the United States stationed in this state in accordance with military orders or stationed in this state before a temporary assignment to duties outside of this state; or are you the spouse of such member? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Attach military orders, duty station assignment, base identification, etc. Depending on submissions, your application may be processed as a military application.</p>			

Licensure and Registration History
Are you currently, or have you ever been, licensed or registered as a dental professional in North Dakota? Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes, provide: Title of license/registration you held: _____ Name under which you were licensed/registered: _____ Registration/license number: _____ Permits you held under that license/registration (e.g., local anesthetic, nitrous oxide administration, etc.): _____

Are you currently, or have you ever been, licensed as a dental professional outside of North Dakota?  Yes <input type="checkbox"/> No <input type="checkbox"/>
If you checked "yes" immediately above, list each state, country, or jurisdiction, and the corresponding license/registration number(s).
Licensure verification from each jurisdiction listed in is required. Licensing authorities that do not have public online verification must send original license verifications directly to the Board at <a href="mailto:info@nddentalboard.org">info@nddentalboard.org</a>

Education (select one)	
Completed the DANB NELDA:  <input type="checkbox"/> <b>Within one year</b> of this application; or  <input type="checkbox"/> <b>More than one year before</b> this application (if so, you must submit proof of earning 16 CE within the two years prior to application).	Date of Completion: _____  Provide the NELDA certifications (Raditional Health and Safety; Infection Control; and Anatomy, Morphology, and Physiology)
Completed either the DA Prep or Bismarck State College QDA Program:  <input type="checkbox"/> <b>Within one year</b> of this application; or  <input type="checkbox"/> <b>More than one year before</b> this application (if so, you must submit proof of earning 16 CE within the two years prior to application).	Name of Program: _____  Date of Completion: _____  Attached completion certificate.
<input type="checkbox"/> Completed the North Dakota Department of Career and Technical Education's Dental Assisting Program <b>within two years</b> of this application, and earned the DANB NELDA certification (e.g., the RHS, IC, and AMP examinations).	Date of Completion of CTE Program: _____  Attach CTE and NELDA completion certificates.
If you completed a dental assisting program that is substantially similar to those listed above you may qualify for registration as a QDA. The Board must fully assess your program and work history to ensure the application meets regulatory requirements. Please submit:  <input type="checkbox"/> Documents outlining the program's curriculum, hours, and content of the program;  <input type="checkbox"/> Documentation confirming you worked at least 300 hours in dental assisting (e.g., payroll records, letters from supervising dentists, tax forms); and  <input type="checkbox"/> If you completed the program more than one year prior to this application, submit proof of earning 16 CE within the last two years.	Other Dental Assiting Program Completed  Name: _____  Location: _____  Date of Completion: _____

<p>If you have worked as a dental assistant outside of North Dakota with a scope of practice comparable to that of a QDA in North Dakota, you may qualify for registration as a QDA. Please submit:</p> <p><input type="checkbox"/> Copies of the other state's laws under which you worked, including the scope of practice;</p> <p><input type="checkbox"/> Documents showing you possess qualifications, education, or experience substantially similar to North Dakota's requirements for a QDA (e.g., letters from dentists, a written narrative, an explanation and documentation of any dental assisting education or continuing education you completed; training you received);</p> <p><input type="checkbox"/> Evidence of at least one year of gainful and relevant employment in the practice of dental assisting e.g., W-2s, payroll records, letters from dentists); and,</p> <p><input type="checkbox"/> Evidence of earning 16 hours of continuing education in accordance with section 20-03-01-06.</p>	<p>Other State: _____</p> <p>Other license/registration name: _____</p> <p>Other license/registration number: _____</p>
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<b>Cardiopulmonary Resuscitation or Basic Life Support (applicants must hold either current CPR or BLS certification)</b>
<p>Hold an active cardiopulmonary resuscitation (CPR) certification; course must include a hands-on component.  Yes <input type="checkbox"/> No <input type="checkbox"/> Expiration date: _____</p> <p>Basic life support (BLS) certification.  Yes <input type="checkbox"/> No <input type="checkbox"/> Expiration date: _____</p> <p>Attach certificates.</p>

<b>Infection Control</b>
<p>Date of most recent completion of infection control program (must be within two years): _____</p> <p>Name of infection control education program or examination: _____</p> <p>Attach documentation. Acceptable programs include continuing education, completion of DANB examinations or equivalent certification exams, or other infection control programming.</p>

<b>Disclosures</b>	
Are you under investigation, are you the subject of any pending or past disciplinary action, or have you ever been refused a dental professional license or any other occupational license in any state, territory or country? If so, attach a statement describing the reason for investigation, disciplinary action, refusal of license, etc. Include the dates, the disposition, and contact information for the licensing authority.	Yes <input type="checkbox"/> No <input type="checkbox"/>
Have you been arrested for alleged criminal conduct, or are there any criminal charges pending against you? If so, attach a statement detailing the reasons for the charges, the dates, the name and location of the court, and the case number.	Yes <input type="checkbox"/> No <input type="checkbox"/>
Have you ever been convicted of a felony, gross misdemeanor, or a misdemeanor? If so, attach a statement detailing the reasons for the charges, the dates, the name of the court, and the case.	Yes <input type="checkbox"/> No <input type="checkbox"/>
Are there any unsatisfied judgments against you that resulted from practicing in the dental field? If so, attach a statement detailing the nature of the judgment, the dates, and the reasons for non- payment.	Yes <input type="checkbox"/> No <input type="checkbox"/>
Do you currently have a condition related to an alcohol use disorder or other substance use disorder that adversely affects your ability to practice dental assisting in a competent and professional manner with reasonable skill and safety? If you responded YES, you must attach an explanation. If you responded NO, you must immediately inform the Board if such a condition arises.	Yes <input type="checkbox"/> No <input type="checkbox"/>
Do you currently have any physical, mental health, or cognitive condition that impairs your judgement or that adversely affects your ability to practice dental assisting in a competent and professional manner with reasonable skill and safety? If you responded YES, you must attach an explanation. If you responded NO, you must immediately inform the Board if such a condition arises.	Yes <input type="checkbox"/> No <input type="checkbox"/>

<b>Official Identification</b>
<p>Include a copy of an official and current U.S. Government Issued I.D. (Examples – Driver’s License, State Identification Card, Real ID, Passport, Visa)</p> <p>Type of identification: _____</p> <p>Date of expiration: _____</p>

<b>Attestation of Applicant</b>		
I have reviewed North Dakota Century Code §§ 43-20-05 and 43-28-25, and understand that including false information or false documentation in this application may result in denial of my application and could result in a class A misdemeanor.	Yes <input type="checkbox"/> No <input type="checkbox"/>	
I certify that I am the person referred to in this application for licensure or registration.	Yes <input type="checkbox"/> No <input type="checkbox"/>	
I certify that the entirety of this application and the attached materials are true and correct.	Yes <input type="checkbox"/> No <input type="checkbox"/>	
I authorize all persons and organizations to release any requested information, files, or records in connection with this application to the North Dakota State Board of Dental Examiners.	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Applicant’s Name (Printed)	Applicant’s Signature	Date (mm/dd/yyyy)