North Dakota State Board of Dental Examiners

PO Box 7246, Bismarck, ND 58507-7246 | Phone 701-258-8600
Web www.nddentalboard.org | Email info@nddentalboard.org

Application for Qualified Dental Assistant-Limited Radiology Registrant

Applicable Laws for QDA-LRR

- N.D.A.C. 20-03-01-05(3) explains the criteria for registering as a Qualified Dental Assistant-Limited Radiology Registrant and N.D.A.C. 20-03-01-01(3) explains the duties a Qualified Dental Assistant-Limited Radiology Registrant 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.**
- 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, or mail them to the address above.

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 your application is granted, you must always 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.

North Dakota State Board of Dental Examiners

PO Box 7246, Bismarck, ND 58507-7246 | Phone 701-258-8600
Web www.nddentalboard.org | Email info@nddentalboard.org

Application for Qualified Dental Assistant-Limited Radiology Registrant

Non-refundable Fee: $100.00

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)			
Name as you wish it to appear on license (if not your current legal name, you must provide documentation of name change)			
Home Street Address	Apt. Number	Home City, State, Zip (4+ digits)	
Phone Numbers (c) (h) (w)	Business/Employer Name, Address, Unit #	Employer/Business City, State, Zip (4+ digits)	
Personal Email Address **(required)**	Business/Employment Email Address		
Gender Male ☐ Female ☐ X ☐	Date of Birth (mm/dd/yyyy)	Social Security Number	

Military Status: 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 ☐ No ☐

Attach military orders, duty station assignment, base identification, etc. Depending on submissions, your application may be processed as a military application.

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

Are you currently, or have you ever been, licensed/registered as a dental professional outside of North Dakota? Yes ☐ No ☐
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 **info@nddentalboard.org.**

Education for QDA-LRR (select one)	
Within two years of this application date, you either: ☐ Passed the DANB Radiation Health and Safety Exam; ☐ Completed the Radiation Health and Safety program offered by either DA Prep or Bismarck State College; or ☐ Completed a Radiation Health and Safety Program other than those listed above (If you selected this option, the Board must fully assess your program to ensure it meets regulatory requirements in North Dakota. You must submit documents outlining the curriculum, hours, and content of the program).	Name of Program: _____ Location of Program:_____ Date of Completion: _____
More than two years before the date of this application, you either: ☐ Passed the DANB Radiation Health and Safety Exam; ☐ Completed the Radiation Health and Safety program offered by either DA Prep or Bismarck State College; or ☐ Completed a Radiation Health and Safety Program other than those listed above (If you selected this option, the Board must fully assess your program to ensure it meets regulatory requirements in North Dakota. You must submit documents outlining the curriculum, hours, and content of the program).	Name of Program: _____ Location of Program:_____ Date of Completion: _____ Applicants who completed their RHS education more than two years prior to this application must submit a letter from a dentist confirming that the applicant has successfully taken radiographs within five years of this application. Name of Dentist: _____

Cardiopulmonary Resuscitation or Basic Life Support (applicants must hold either current CPR or BLS certification)
Hold an active cardiopulmonary resuscitation (CPR) certification; course must include a hands-on component. Yes ☐ No ☐ Expiration date: _____ Basic life support (BLS) certification. Yes ☐ No ☐ Expiration date: _____ Attach certificates.

Disclosures	
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 ☐ No ☐
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 ☐ No ☐
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 ☐ No ☐
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 ☐ No ☐
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 ☐ No ☐
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 ☐ No ☐

Official Identification
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) Type of identification: _____ Date of expiration: _____

Attestation of Applicant		
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 ☐ No ☐
I certify that I am the person referred to in this application for licensure or registration.		Yes ☐ No ☐
I certify that the entirety of this application and the attached materials are true and correct.		Yes ☐ No ☐
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 ☐ No ☐
Applicant's Name (Printed)	Applicant's Signature	Date (mm/dd/yyyy)