



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 – Restorative Care Permit

Who May Apply

- Applicants must be one of the following in order to be granted a Restorative Care Permit:
 - Registered Dental Hygienist
 - Registered Dental Assistant

Applicable Laws for Restorative Care Permit

- N.D.A.C. 20-03-01-01.2(3) explains the criteria for those seeking a Restorative Care Permit.
- N.D.A.C. 20-03-01-01.1(1) explains the duties a permit holder may perform, and that all duties must be carried out under direct supervision.
- Applicants must thoroughly review N.D.A.C. [20-03-01.pdf](#), and be able to demonstrate an understanding of the laws cited above, including the requirement of obtaining patient informed consent before the permit holder may place restorations and the requirement that the final restorations shall be checked and documented by the supervising dentist.

Application

- Be sure to attach/download additional materials and documents as requested.
- If you have questions on the application and or materials, please email us at: info@nddentalboard.org
- When completing this application, you will be required to provide proof of their restorative care education. Approved courses are listed on the website. If you are unsure if your course has received Board-approval, contact the Board before applying.

Accepted Forms of Payment

- 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.



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Non-refundable Fee: \$50.00

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 <input type="checkbox"/> Female <input type="checkbox"/> X <input type="checkbox"/>		Date of Birth (mm/dd/yyyy)	Social Security Number
<p>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 <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>			

Education (select one)	
<input type="checkbox"/> Within five (5) years of this application, 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 program	Name of Program: _____ Location of Program: _____ Date of Completion: _____

<p>(Courses must include clinical and written examinations).</p> <p>Note that the Board may require successful completion of the restorative function component of the DANB's certified restorative functions dental assistant certification examination.</p>	<p>Submit certification of completion.</p>
<p>More than five (5) years prior to this application passed a Board-approved dental testing agency examination, and submits all of the following:</p> <p><input type="checkbox"/> Proof of passage of the restorative function component of the DANB's certified restorative functions dental assistant certification examination or other Board-approved examination;</p> <p><input type="checkbox"/> Evidence from another state or jurisdiction where the applicant legally is or was authorized to perform restorative functions; and</p> <p><input type="checkbox"/> Confirmation from a supervising dentist that the applicant successfully completed at least twenty-five restorative procedures within the immediate five years from the date of application.</p>	<p>Name of Testing Agency Exam: _____</p> <p>Location of Exam: _____</p> <p>Date of Completion: _____</p> <p>Other state/jurisdiction: _____</p> <p>Other State Authorization: _____</p> <p>Name of Dentist: _____</p>

Cardiopulmonary Resuscitation or Basic Life Support (applicants must hold either current CPR or BLS certification)	
<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>	

Attestation of Applicant	
<p>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.</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>
<p>I certify that I am the person referred to in this application.</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>
<p>I certify that the entirety of this application and the attached materials are true and correct.</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>
<p>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.</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>

Applicant's Name (Printed)	Applicant's Signature	Date (mm/dd/yyyy)
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