

will not be considered.

North Dakota Board of Dental Examiners

PO Box 7246, Bismarck, ND 58507-7246 • Phone 701-258-8600 • Fax 701-224-9824 Web www.nddentalboard.org | Email info@nddentalboard.org

Application for Initial Registration | Reinstatement of Expired License Registered Dental Assistant & Qualified Dental Assistant

Non Refundable Application Fee: \$145.00

OFFICE USE ONLY - Postmark Date:	Date Received	Amount Check #		
of dental assisting must register with the Board. Please type or print clearly. supporting documents for registration may result in a delay in processing you of the ND Rules and Regulations jurispers Board. Successful completion of the experience of the experience of the second completion.	ne Board of Dental Examiner Follow the instructions proving as a Registered Dental Assistration. Once your apprudence examination will be sam is required for your dental assistant as sequired for your dental as your	ndividual engaged in performing expanded duties in a by submitting application accompanied by a fee detided. It is the responsibility of the applicant to submit stant (RDA) or Qualified Dental Assistant (QDA). Fails plication has been submitted with supporting document to you. Complete the open-book exam and retital assistant registration. Note: The mailing and emain to maintain current contact information with the Bo	termine all requ ure to d ents, a urn it to ail addro	ed by uired do so copy o the
IDENTIFYING INFORMATION				
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		
DISCLOSURE				
 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? 				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?				NO
application. If you do not provide the d	ocuments, your application is	d copies of all court documents related to your criminal hist incomplete and will not be considered. A criminal hist port criminal history may result in extra cost to you and the	tory ma	ay not
Have you ever been charged with	or convicted of any crime, felo	ny, or misdemeanor?	YES	NO
the criminal charges, reported offense, p disposition, any orders or any actions pend	police report and judgment and ing. Please send your information			
 Have you ever surrendered a cred federal, or any other authority? 	dential like those listed in numb	er 7, in connection with or to avoid action by a state,	YES	NO
5. 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?				NO
If you answered "yes" to question 5, you investigating and/or prosecuting the charg	must explain the nature of the es. This includes any city, coun	prosecution and/or charge(s). You must include the jurisdity, state, federal or tribal jurisdiction. If charging documents you do not provide the documents, your application is in	nts have	e been

6. Have you ever been convicted, entered a plea of guilty, no contest, or a similar plea, or had prosecution or a sentence deferred or suspended in any state or jurisdiction?	YES	NO			
7. 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?					
d. Prescribed controlled substances for yourself?					
e. Been cited for operating a motor vehicle while under the influence of drugs or alcohol?	YES	NO			
8. 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.		NO			
9. Are you now subject to criminal prosecution or pending charges of a crime in any state or jurisdiction?	YES	NO			
10. Date of your last infection control course. [Must be within 24 months]/ Attach doc	umentation.				
11. Attach a copy of your CPR card. [Must be within the last 24 months] Online CPR coursework is <u>not</u> acceptable for	this requireme	ent.			
QUALIFICATIONS					
12. Graduates from an ADA accredited dental assisting program are eligible to apply pit and fissure sealants. Dental assist a Board authorized training course or are office trained and have successfully challenged the DANB exam, must su this coursework. Documentation may include class syllabus, course outline or certificate of training from course attach any supporting documentation.	bmit documer	ntation of			
Name and location of course Name and location of course Month/Year 13. Before monitoring nitrous oxide inhalation analgesia, office trained dental assistants who have successfully taken the DANB exam or dental assistants who have passed a Board authorized training course must show proof of nitrous oxide training. Documentation may include class syllabus, course outline or certificate of training from course sponsors or instructors. Attach any supporting documentation.					
Name and location of course 14. Name of Board approved or ADA accredited program you graduated from. [Attach copy of the transcript.]					
Name and location of program Mo	nth/Year				
OR 15. Are you an office-trained dental assistant? Yes No Attach copy of DANB certificate or test, and evidence of office hours (pay stubs, W-2 Form, time sheets) 16. QUALIFIED ASSISTANTS ONLY: Attach documentation of DANB Radiation Health and Safety Exam and DANB Infection Control Exam. 17. REINSTATEMENT of EXPIRED 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.					
Attestation: I certify I have completed the requirements of this application including CPR and infection control of and understand I must maintain a current cardiopulmonary resuscitation certificate. I understand that should I information, my registration may be denied, or if issued, suspended or revoked. This registration expires December 1.	provide any	false			
Signature of dental assistant: Date:/	/20				
Application Fee: \$145.00 Fee is non-refundable. Make check payable to NDBDE. Incomplete applications will not be processed. Mail supporting documents, fee, and signed application to: NDBDE PO Box 7246					
Bismarck, ND 58507-7246					