

**APPLICATION INSTRUCTIONS FOR REGISTRATION AS A  
DENTAL ASSISTANT II**

A completed application shall include the following unless otherwise stated below. An incomplete application and/or fee will delay the processing of your application. Incomplete applications are kept for one year.

- \_\_\_\_\_ **1.Application:** Please be sure that all information and questions are completed on the application.
- \_\_\_\_\_ **2.Application Fee:** The fee for Registration as a Dental Assistant II is **\$100** and must be paid with a certified check, cashier's check or money order, made payable to **The Treasurer of Virginia**. The fee can be used for one year from date of receipt. Pursuant to 18VAC60-30-30(F), all fees are non-refundable. Your application will not be reviewed until you have submitted payment.
- \_\_\_\_\_ **3.Form A:** Original certification of completion of an expanded function dental assisting training program which was obtained from an educational institution that maintains a program in dental assisting, dental hygiene or dentistry accredited by the Commission on Dental Accreditation of the American Dental Association (CODA).
- \_\_\_\_\_ **4.Evidence of a current credential as a **Certified Dental Assistant** (CDA) conferred by the Dental National Board (DANB) or another certification from a credentialing organization recognized by the American Dental Association and acceptable to the board.**
- \_\_\_\_\_ **5.Certification of Completion of Education:** Transcript, certification and documentation of the training content completed confirming the educational requirements set forth in 18VAC60-30-120 of the Regulations Governing the Practice of Dental Assistants have been met.
- If applying by endorsement:** If you are applying for Registration by endorsement you **must** hold a credential, registration, or certificate with qualifications substantially equivalent in hours of instruction and course content to those set forth in 18VAC60-30-120 **or** if your expanded function dental assisting program was not substantially equivalent to Virginia's educational requirements set forth in 18VAC60-30-120 of the Regulations Governing the Practice of Dental Assistants, you **must** submit **Form B**, which is to be completed by a supervising dentist(s), documenting your experience in the restorative and/or prosthetic expanded duties that you are applying to perform in Virginia, for at least 24 of the past 48 months preceding your application for registration in Virginia.
- \_\_\_\_\_ **6.Form C:** Original licensure verification from any jurisdiction in which you currently hold or have ever held a license/registration/certification to practice as a dental assistant or as another health care professional **and** certification of authorization to perform expanded duties as a dental assistant Copies of permits are not accepted. Verification cannot be older than 6 months from date prepared.

\_\_\_\_\_ **7.Name Change:** Documentation must be provided to show each name change(s) if your name has ever been changed from the time you attended school or were licensed in other jurisdictions or other than what is listed on your application. Photocopies of marriage licenses or court orders are accepted.

\_\_\_\_\_ **8.**Please be aware that your signed, notarized application affidavit authorizes the release of confidential information, affirms that your application is complete and correct, and attests that you have read and understand and will remain current with the laws and the regulations governing the practice of dentistry in Virginia.

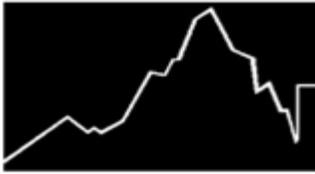
## **FYI**

Accredited Program Information  
American Dental Association  
Commission on Dental Accreditation  
211 East Chicago Avenue  
Chicago, IL 60611-2678  
312-440-2500  
[www.ada.org/coda](http://www.ada.org/coda)

Dental Assisting National Board, Inc.  
444 N. Michigan Avenue  
Suite 900  
Chicago, IL 60611-3985  
1-800-367-3262  
[www.danb.org](http://www.danb.org)  
[danbmail@danb.org](mailto:danbmail@danb.org)

## **NOTES:**

- If your Virginia registration is not issued within six months of the Board's receipt of parts of the application, certain portions of the application may need to be updated or resubmitted before your application can be reviewed.
- You might obtain the Virginia laws and the regulations governing the practice of dentistry at [www.dhp.virginia.gov/dentistry](http://www.dhp.virginia.gov/dentistry).
- Within approximately 10 business days of receipt of application, applicants will be notified of missing application items.
- To receive notice that your supporting documents have been delivered to the board, it is suggested that the documents be mailed by "Certified Mail-Return Receipt Requested" or with "Delivery Confirmation".
- Documents submitted with an application are the property of the Board and cannot be returned.
- Consistent with Virginia law §54.1.2400.02 and mission of the Department of Health Professions, addresses of licensees are made available to the public. Normally, the Address of record is the publically disclosable address. If you do not want your Address of Record to be made public, state law allows you to provide a second, publically disclosable address. Typically, this other address is the work or practice address. If you would like for your Address of Record to be made available to the public, complete both sections with the same address.



Virginia Board of Dentistry  
 9960 Mayland Drive, Suite 300  
 Henrico, VA 23233-1463  
 804-367-4538  
[www.dhp.virginia.gov/dentistry](http://www.dhp.virginia.gov/dentistry)

## APPLICATION FOR REGISTRATION AS A DENTAL ASSISTANT II

Check the box that applies:

BY EDUCATION

BY ENDORSEMENT

**INSTRUCTIONS:** Type or print clearly. Complete all sections. If the space provided for any answer is insufficient, complete your answer on a separate page, specify the number of the question to which it relates, sign the page and enclose it with the application.

Name: Last	First	Middle/Maiden	Suffix
Address of record (Mailing Address)	City	State	Zip Telephone Number
Public Disclosable Address	City	State	Zip Telephone Number
E-mail Address	Fax #		
Date of Birth ____/____/____	*Social Security Number or Virginia DMV control Number ____-____-____		
Graduation Date:	Dental Assisting Expanded Duties Program/School:	City/State:	

### APPLICANTS DO NOT USE SPACES BELOW THIS LINE –FOR OFFICE USE ONLY

Date received	Fee	Applicant #	
Registration #	Date Issued	Certification of Education/Form B	DANB Certification

**\*In accordance with §54.1-116 of the Code of Virginia, you are required to submit your Social Security Number or your control number issued by the Virginia Department of Motor Vehicles. If you fail to do so, the processing of your application will be suspended and fees will not be refunded. This number will be used by the Department of Health Professions or identification and will not be disclosed for other purposes except as provided for by law. Federal and state law requires that this number be shared with other agencies for child support enforcement activities.**

**I am applying to perform:** (check all that apply)

- 1. Performing pulp capping procedures
- 2. Packing and carving of amalgam restorations;
- 3. Placing and shaping composite resin restorations with a slow speed hand piece;
- 4. Taking final impressions;
- 5. Use of a non-epinephrine retraction cord;
- 6. Final cementation of crowns and bridges after adjustment and fitting by the dentist.

a. List in chronological order the dental assistant programs attended:

Begin Date	Completion Date	Name of School	Degree/Certificate Awarded
_____	_____	_____	_____
_____	_____	_____	_____

b. Dental Assisting National Board Certification or other Certified Dental Assistant Certification:

Certification Number	Date Issued	Expiration Date
_____	_____	_____

c. List all licenses/registrations/certificates which you have been issued to practice as a dental assistant or as any other health care professional.

Jurisdiction	License Number	Date Issued	Date Expired
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

- d. Have you ever been convicted of a violation or plead Nolo Contedere, to any federal, state or local statute, regulations or ordinance, or entered into any plea bargaining relating to a felony misdemeanor (excluding traffic violations, except convictions for driving under the influence)? [ ] Yes [ ] No  
**If yes, give details, jurisdiction(s) and date(s) on a separate page, and include a copy of the disposition/record certified by the Clerk of the Court.**
- e. Are you the spouse of a member of the U.S. military who has been transferred to Virginia and did you leave employment to accompany your spouse to Virginia? [ ] Yes [ ] No
- f. Have you ever been denied a license? If yes, give details, jurisdiction(s) and date(s) on a separate page. [ ] Yes [ ] No
- g. Have you ever voluntarily surrendered your clinical privileges while under investigation, been censured or warned or been requested to withdraw from the staff of any hospital, nursing home or other health care facility, or any health care provider? If yes, give details, jurisdiction(s) and date(s) on a separate page. [ ] Yes [ ] No
- h. Have you ever been a defendant in a military court martial or received medical or other than honorable discharge? If yes, give details, jurisdiction(s) and date(s) on a separate page. [ ] Yes [ ] No
- i. Have you, within the last two (2) years, received treatment for, or been hospitalized for a nervous, emotional or mental disorder? If yes, give details, jurisdiction(s) and date(s) on a separate page and provide a letter of explanation from the treating professional(s), including summary of diagnoses, treatment and prognosis. [ ] Yes [ ] No
- j. Do you have a physical disability, disease or diagnosis which could affect your performance or professional duties? If yes, provide a letter of explanation from the treating professional(s), including a summary of diagnosis, treatment and prognosis. [ ] Yes [ ] No

- k. Have you been adjudged mentally incompetent, or been voluntarily or involuntarily committed to a mental institution within the last five (5) years? If yes, give details, jurisdiction(s), and date(s) on a separate page and provide certified copies of all applicable court documents. [ ] Yes [ ] No
- l. Did you relocate with a spouse who is the subject of a military transfer to the Commonwealth of Virginia? [ ] Yes [ ] No

**APPLICATION AFFIDAVIT**  
**(MUST BE COMPLETED BEFORE A NOTARY PUBLIC)**

I, \_\_\_\_\_, being first duly sworn, depose and say that I am the person referred to in the foregoing application and supporting documents.

I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past and present) business and professional associates (past and present) and all governmental agencies and instrumentalities (local, state, federal or foreign) to release to the Virginia Board of Dentistry any information, files or records requested by the Board which is material to me and my application.

I have carefully read the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me in the application and supporting documents are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for the denial, suspension, or revocation of my license to practice in the Commonwealth of Virginia.

I have carefully read the laws and regulations related to the practice of dentistry and dental hygiene. I hereby agree to abide by and remain current with the applicable laws and regulations which are available on [www.dhp.virginia.gov](http://www.dhp.virginia.gov), and

I have attached a certified check, cashier's check or money order in the amount of \$\_\_\_\_\_ made payable to the Treasurer of Virginia. I fully understand that funds submitted as part of the application shall not be refunded.

\_\_\_\_\_  
Signature of Applicant

State of \_\_\_\_\_

County/City of \_\_\_\_\_

Sworn and subscribed to, before me, this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_  
Day Month Year

My commission expires on \_\_\_\_\_.

\_\_\_\_\_  
Signature of Notary Public

**COMMONWEALTH OF VIRGINIA**  
VIRGINIA BOARD OF DENTISTRY  
9960 MAYLAND DRIVE, SUITE 300  
Henrico, VA 23233-1463  
804-367-4538 [www.dhp.virginia.gov/dentistry](http://www.dhp.virginia.gov/dentistry)

**FORM A**  
**CERTIFICATION OF COMPLETION OF DENTAL ASSISTING EDUCATION**

APPLICANT: ENTER YOUR NAME AND GRADUATION DATE BELOW THEN SEND THIS FORM TO THE DEAN OR DIRECTOR OF EACH DENTAL ASSISTING PROGRAM THAT YOU HAVE COMPLETED.

APPLICANT \_\_\_\_\_ GRADUATION DATE: \_\_\_\_\_

**DEAN/PROGRAM DIRECTOR:** Please provide certification that the applicant named above successfully completed an expanded duties dental assisting program that includes training in each item you check here:

- \_\_\_\_\_ (1) Performing pulp capping procedures
- \_\_\_\_\_ (2) Packing and carving amalgam restorations
- \_\_\_\_\_ (3) Placing and shaping composite resin restorations with a slow speed hand piece
- \_\_\_\_\_ (4) Taking final impressions
- \_\_\_\_\_ (5) Use of a non-epinephrine retraction cord
- \_\_\_\_\_ (6) Final cementation of crowns and bridges after adjustment and fitting by the dentist.

**Please attach** the transcript, certification and documentation of the training content completed confirming the educational requirements set forth in 18VAC60-30-120 of the Regulations Governing the Practice of Dental Assistants have been met.

This form also certifies that the program completed was given by an institution that **maintains a program in dental assisting, dental hygiene or dentistry** accredited by the Commission on Dental Accreditation of the American Dental Association (CODA).

These certifications may be provided by completing this form or by providing a letter with all the information requested on this form. Either document must bear the school's seal. The certification may be returned to the applicant. Certifications made prior to the applicant's graduation cannot be accepted.

NAME OF SCHOOL: \_\_\_\_\_

NAME OF PROGRAM: \_\_\_\_\_

SCHOOL'S PROGRAM(S) THAT MAINTAINS CODA ACCREDITATION; INCLUDING ITS STATUS: \_\_\_\_\_

DEGREE or CERTIFICATION GRANTED: \_\_\_\_\_

DATE GRANTED: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Month Day Year

By affixing my signature below, I certify that the applicant named above is a graduate and a holder of a diploma or a certificate.

\_\_\_\_\_  
Signature

**(SEAL)**

\_\_\_\_\_  
Title

\_\_\_\_\_ Date \_\_\_\_\_

**COMMONWEALTH OF VIRGINIA**  
**BOARD OF DENTISTRY**  
Department of Health Professions  
9960 Mayland Drive, Suite 300  
Henrico, VA 23233-1463  
(804) 367-4538 [www.dhp.virginia.gov/dentistry](http://www.dhp.virginia.gov/dentistry)

**FORM B**

I, \_\_\_\_\_ D.D.S/D.M.D certify that \_\_\_\_\_  
(Supervising Dentist) (Applicant)

was employed by me from \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_  
Month Day Year Month Day Year

as a dental assistant in performing the following duties:

Check each that apply:

- 1)  Performing pulp capping procedures;
- 2)  Packing and carving of amalgam restorations;
- 3)  Placing and shaping composite resin restorations with a slow speed hand piece;
- 4)  Taking final impressions;
- 5)  Use of a non-epinephrine retraction cord;
- 6)  Final cementation of crowns and bridges after adjustment and fitting by the dentist.

\_\_\_\_\_  
Signature/Date

\_\_\_\_\_  
Phone

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
E-Mail Address

\_\_\_\_\_

Notary

State of \_\_\_\_\_

County/City of \_\_\_\_\_

Sworn and subscribed to, before, this \_\_\_\_ day of (Month) \_\_\_\_\_, Year \_\_\_\_\_.

My Commission expires on \_\_\_\_\_.

\_\_\_\_\_  
Signature of Notary Public

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**BOARD OF DENTISTRY**  
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**FORM C**  
**CERTIFICATION OF AUTHORIZATION TO PERFORM EXPANDED DUTIES AS A DENTAL ASSISTANT**

Please forward one form to each state dental board where you hold or have ever held registration as a dental assistant. Some states require a fee, paid in advance, for providing this information. To expedite, you may wish to contact the applicable state board(s). Form C may be photocopied if copies are needed.

**I am making application for registration as a dental assistant II in Virginia:**

I, \_\_\_\_\_, was granted License/registration Number \_\_\_\_\_ on \_\_\_\_\_ by the State of \_\_\_\_\_.  
(DATE)

The Virginia Board of Dentistry requests that I submit evidence that my license/registration in the State of \_\_\_\_\_ is in good standing. You are hereby authorized to release any information in your files, favorable or otherwise directly to the Virginia Board of Dentistry. Your early attention is appreciated.

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date

**Executive officer of State Board: Please complete and return this form to the applicant. If disciplinary action has been taken, return the form to the Board of Dentistry.**

State of \_\_\_\_\_ Name of Licensee \_\_\_\_\_

License # \_\_\_\_\_ Issued \_\_\_\_\_

By  Reciprocity  Examination  Endorsement with the State of \_\_\_\_\_

License Status and Expiration Date: \_\_\_\_\_

Please check all duties the licensee is currently authorized to perform:

- 1)  Performing pulp capping procedures;
- 2)  Packing and carving of amalgam restorations;
- 3)  Placing and shaping composite resin restorations with a slow speed hand piece;
- 4)  Taking final impressions;
- 5)  Use of a non-epinephrine retraction cord;
- 6)  Final cementation of crowns and bridges after adjustment and fitting by the dentist.

Has applicant's license ever been disciplined, suspended or revoked  NO  YES

If yes, give details and attach supporting documentation (Finding of Fact, Conclusions of Law, Orders): \_\_\_\_\_

**SEAL**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Title

**18VAC60-30-120. Educational requirements for dental assistants II.**

A. A prerequisite for entry into an educational program preparing a person for registration as a dental assistant II shall be current certification as a Certified Dental Assistant (CDA) conferred by the Dental Assisting National Board.

B. To be registered as a dental assistant II, a person shall complete the following requirements from an educational institution that maintains a program in dental assisting, dental hygiene or dentistry accredited by CODA:

1. At least 50 hours of didactic course work in dental anatomy and operative dentistry that may be completed online.
2. Laboratory training that may be completed in the following modules with no more than 20% of the specified instruction to be completed as homework in a dental office:
  - a. At least 40 hours of placing, packing, carving, and polishing of amalgam restorations and pulp capping procedures;
  - b. At least 60 hours of placing and shaping composite resin restorations and pulp capping procedures;
  - c. At least 20 hours of taking final impressions and use of a non-epinephrine retraction cord; and
  - d. At least 30 hours of final cementation of crowns and bridges after adjustment and fitting by the dentist.
3. Clinical experience applying the techniques learned in the preclinical coursework and laboratory training that may be completed in a dental office in the following modules:
  - a. At least 80 hours of placing, packing, carving, and polishing of amalgam restorations;

- b. At least 120 hours of placing and shaping composite resin restorations;
  - c. At least 40 hours of taking final impressions and use of a non-epinephrine retraction cord; and
  - d. At least 60 hours of final cementation of crowns and bridges after adjustment and fitting by the dentist.
4. Successful completion of the following competency examinations given by the accredited educational programs:
- a. A written examination at the conclusion of the 50 hours of didactic coursework;
  - b. A practical examination at the conclusion of each module of laboratory training; and
  - c. A comprehensive written examination at the conclusion of all required coursework, training, and experience for each of the corresponding modules.
- C. All treatment of patients shall be under the direct and immediate supervision of a licensed dentist who is responsible for the performance of duties by the student. The dentist shall attest to successful completion of the clinical competencies and restorative experiences.