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

FORM A
CERTIFICATION 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 checked: (1) Performing pulp capping procedures, (2) Packing and carving of amalgam restorations; (3) Placing and shaping composite resin restoration; (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, AND attach a detailed program description or course syllabi that specifies the content and didactic, laboratory and clinical hours required to complete the program. This form also certifies that the program completed was accredited by the Commission on Dental Accreditation of the ADA (CODA). The certification may be provided by completing this form or by providing a letter with the information requested on this form. Either document must bear the school's seal. The certification should be returned to the APPLICANT. Certifications made prior to the applicant's graduation cannot be accepted.

NAME OFSCHOOL: _____

NAME OF PROGRAM: _____

PROGRAM'S CODA ACCREDITATION 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