

INSTRUCTIONS FOR REGISTRATION OF DENTAL ASSISTANT II

There are **two** pathways for registration in Virginia, **registration by education** or **registration by endorsement**. Read through the application instructions carefully before deciding which pathway to pursue. 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 remain active for one year from the date of receipt. After one year from date of receipt, you would need to reapply. Documents submitted with an application are the property of the Board of Dentistry and cannot be returned.

- _____ 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. 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.
- _____ 4. **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). Applicants must submit a Form A for **each** degree and/or certificate earned from a dental program accredited by CODA. The school may use this form or its own form to meet this requirement. The certification must bear the school's seal or be on letterhead and must include the program's CODA accreditation status at the time you completed the program. This information is only accepted from programs accredited by CODA. Documentation from foreign schools is not required and will not be considered.
- _____ 5. **Transcript (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 (Form B): 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.

For example, the four year period immediately preceding an application received on October 15, 2018 began on October 16, 2014. The four calendar years for this example application are:

First year: October 16, 2014 to October 15, 2015;
Second year: October 16, 2015 to October 15, 2016;
Third year: October 16, 2016 to October 15, 2017, and;
Fourth year: October 16, 2017 to October 15, 2018

- _____ 6. **Form C:** Original licensure, certification or registration status verification from every 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. Please be aware that your signed and notarized application affidavit authorizes the release of confidential information, affirms that your application is complete and correct, and attests that you have read, understand, and will remain current with the laws and regulations governing the practice of dentistry in Virginia. Review the laws and regulations via the “Laws and Regulations” tab at www.dhp.virginia.gov/dentistry.
- _____ 8. **Name Change:** Documentation must be provided to show each name change, if your name has ever been changed since graduation from a CODA or CDAC accredited program 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. **Address of Record and Publically Disclosable Address:** Consistent with Virginia law §54.1.2400.02 and the 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.

Related contact information:

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

Dental Assisting National Board, Inc.
 444 N. Michigan Avenue, Suite 900
 Chicago, IL 60611-3985
 1-800-367-3262
www.danb.org
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 resubmitted before your application can be reviewed.
- To receive notice that your application has been delivered to the Board, it is suggested that the documents be mailed by “Certified Mail-Return Receipt Requested” or with “Delivery Confirmation”.
- Applicants will be notified of missing application items within approximately 15 business days of receipt of an application. Once your application is complete, allow 30 business days processing time.
- **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.



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APPLICATION FOR REGISTRATION OF DENTAL ASSISTANT II Page 1

Check only 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.

I. GENERAL INFORMATION: COMPLETE ALL SECTIONS (PRINT OR TYPE)

Name: Last*	First	Middle/Maiden	Suffix
Address of Record (Mailing Address)	City	State	Zip Code Telephone Number
Publically Disclosable Address	City	State	Zip Code Telephone Number
Email Address:	Fax Number:		
Date of Birth ____/____/____ Month Day Year	Social Security Number or <u>Virginia</u> DMV Control Number on record** ____-____-____		
Graduation Date:	Dental Assisting Expanded Duties Program/School:	City/State:	

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

- 1. 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.

***Name change: Documentation must be provided to show name change(s) if name has ever been changed from the time you were licensed in Virginia or other jurisdictions.**

****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 for identification and will not be disclosed for other purposes except as provided by law. Federal and state law requires that this number be shared with other agencies for child support enforcement activities.**

FOR OFFICE USE ONLY

FEE AMOUNT	APPLICANT #	REGISTRATION #
Certification of Education/Form B	DANB Certification	Date Issued

II. APPLICANT HISTORY: ALL QUESTIONS MUST BE ANSWERED.
If any of the following questions are answered "YES", explain and substantiate with documentation. Letters must be submitted by your attorney regarding malpractice suits. Letters must be submitted by any treating professionals regarding health treatment and shall include diagnosis, treatment and prognosis.

1. Did you relocate with a spouse who is the subject of a military transfer to the Commonwealth of Virginia? If "YES", include a copy of the official military orders with the application. [] Yes [] No

2. Are you active-duty military? If "YES", include a copy of your official military orders with the application. [] Yes [] No

3. A. List in chronological order the dental assistant programs attended:

Start Date & Completion Date	Name of School/Program (ADA-CODA)	Degree/Certificate Awarded
_____ to _____	_____	_____
_____ to _____	_____	_____
_____ to _____	_____	_____

 B. Dental Assisting National Board Certification or other Dental Assistant Certification:

Certification Number	Date Issued	Expiration Date
_____	_____	_____

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

Jurisdiction	Number	Type	Date Issued	Exp. Date
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

5. Have you ever been denied a license or the privilege of taking a dental licensure/competency examination by a licensing authority? If "YES", give detail(s), jurisdiction(s) and date(s). [] Yes [] No

6. Have you ever been convicted of a violation or plead Nolo Contendere, to any federal, state or local statute, regulations or ordinance, or entered into any plea bargaining relating to a felony or 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.

7. Have you had any malpractice suits brought against you in the past ten (10) years? [] Yes [] No
 If "YES", please provide details for each pending or closed case, list additional claim(s) **on a separate page**, and provide a letter from your attorney explaining each case.
 Claimant: _____ Date of Incident _____
 Name of Defense Attorney: _____
 Settlement or Verdict Amount: _____
 Name of Involved Insurance Company: _____
 Brief description of the claim: _____

Additional licensure questions:

1. A. Within the past five years, have you exhibited any conduct or behavior that could call into question your ability to practice in a competent and professional manner? If "YES", please provide a full explanation. [] Yes [] No

B. Within the past five years, have you sought or been directed to seek treatment for your conduct or behavior? If "YES", please provide a full explanation and any associated orders or letters. [] Yes [] No

2. A. Within the past five years, have you been disciplined by any entity? If "YES", please provide a full explanation and any associated orders or letters from the entity. [] Yes [] No

B. Within the past five years, have you sought or been directed to seek treatment for your conduct or behavior? If "YES", please provide a full explanation and any associated orders or letters. [] Yes [] No

3. Do you currently have any physical condition or impairment that affects or limits your ability to perform any of the obligations and responsibilities of professional practice in a safe and competent manner? [] Yes [] No

"Currently" means recently enough so that the condition could reasonably have an impact on your ability to function as a practicing dentist. If "YES", please provide a full explanation. NOTE: The Board may request a letter from your current treatment provider addressing your current condition and ability to safely practice. You may consider providing this documentation with your application, or have your provider send this documentation directly to the Board.

4. Do you currently have any mental health condition or impairment that affects or limits your ability to perform any of the obligations and responsibilities of professional practice in a safe and competent manner? [] Yes [] No

"Currently" means recently enough so that the condition could reasonably have an impact on your ability to function as a practicing dentist. If "YES", please provide a full explanation. NOTE: The Board may request a letter from your current treatment provider addressing your current condition and ability to safely practice. You may consider providing this documentation with your application, or have your provider send this documentation directly to the Board.

5. Do you currently have any condition or impairment related to alcohol or other substance use that affects or limits your ability to perform any of the obligations and responsibilities of professional practice in a safe and competent manner? [] Yes [] No

"Currently" means recently enough so that the condition could reasonably have an impact on your ability to function as a practicing dentist. If "YES", please provide a full explanation. NOTE: The Board may request a letter from your current treatment provider addressing your current condition

and ability to safely practice. You may consider providing this documentation with your application, or have your provider send this documentation directly to the Board.

6. Within the past 5 years, have any conditions or restrictions been imposed upon you or your practice to avoid disciplinary action by any entity? [] Yes [] No

If "YES", please provide a full explanation and any associated orders or letters from the entity. NOTE: The Board may request a copy of a current participation contract and summary of compliance and/or documentation of successful completion. You may consider providing this documentation with your application, or have the program send this documentation directly to the Board.



Virginia Department of
Health Professions
Board of Dentistry

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FORM A
CERTIFICATION OF COMPLETION OF DENTAL ASSISTING EDUCATION

Applicant: Enter **only** your name and graduation date below, then send this form to the Dean or Director of each School or Program which granted you a dental assisting degree or certificate.

APPLICANT _____ **GRADUATION DATE:** _____

DEAN/PROGRAM DIRECTOR: 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). 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.

Certifications made prior to the applicant's graduation cannot be accepted.

NAME OF SCHOOL: _____

NAME OF PROGRAM: _____

PROGRAM'S CODA ACCREDITATION STATUS ON THE DATE THE DEGREE OR CERTIFICATION WAS GRANTED:

- A1: Approval (without reporting requirements) []
- A2: Approval (with reporting requirements) []
- IA: Initial accreditation []
- DIS: Accreditation voluntarily discontinued []
- WDRN: Accreditation withdrawn []
- X: Intent to withdraw accreditation []
- T: Program is in Teach-Out by institution []
- NE: Required period of non-enrollment []

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.

SEAL

Signature

Print Name

Title

Date

DEAN/REGISTRAR: Please provide the applicant an original final transcript of this alumni record, to include courses, grades, degree or certificate received, and date the degree or certificate was conferred, which bears the certified signature of the registrar and has the college seal affixed.



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FORM B
EXPERIENCE VERIFICATION
(MUST BE COMPLETED BEFORE A NOTARY PUBLIC)

Name of Employing Dentist(s) or Agency: _____

Complete Mailing Address: _____

Telephone Number: _____ Fax Number: _____

Email Address: _____

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

was employed by me from ____/____/____ to ____/____/____ as a dental assistant who
Month Day Year Month Day Year

performed the following expanded 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

Notary:

State of _____

County/City of _____

Sworn and subscribed to, before, this ____ day of (Month) _____, Year _____.

My Commission expires on _____.

Signature of Notary Public

Print Name

SEAL/STAMP



Virginia Department of
Health Professions
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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 in Virginia by:

Examination for Dental Assistant II Endorsement for Dental Assistant II

I, was granted License/Registration Number _____, on _____ by the
Month Date Year

State of _____. The Virginia Board of Dentistry requires that I submit evidence of the status of my license. You are hereby authorized to release any information in your files, favorable or otherwise directly to the **Virginia Board of Dentistry** at **9960 Mayland Drive, Suite 300, Henrico, Virginia 23233** or denbd@dhp.virginia.gov. Your early attention is appreciated.

Applicant's Signature

Applicant's Typed/Printed Name

Applicant's Address

Executive Officer of the Board: please send this form directly to the Virginia Board of Dentistry.

State of _____ Name of Licensee _____

Graduate of _____ License # _____ Issued _____

By: Examination* Credentials Reciprocity with the State of _____ Endorsement with the State of _____

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.

License is: Current-Expires _____ Active Inactive Lapsed-Expired _____

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): _____

Comments, if any: _____

SEAL

Signature

Title

Date

Print Name