

## 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 below following items 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. Some supplemental documentation may be submitted to the Board by mail or email as noted using the information in our letterhead.

- \_\_\_ 1. **Application:** Please be sure that all information and questions are completed on the application. **Not answering all questions and supplying all information will result in a delay of your application. Also, if there are discrepancies in your application, then the Board may ask for additional clarification or may send your application to Enforcement for an investigation.**
- \_\_\_ 2. **Application Fee:** The fee for Registration as a Dental Assistant II is **\$100** and must be paid with a check or money order, made payable to **The Treasurer of Virginia**. The fee is good 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):** A CDA conferred by the Dental Assisting National Board (DANB) or another certification from a credentialing organization recognized by the American Dental Association (ADA) and acceptable to the board, which was granted following passage of an examination on general chairside assisting, radiation health and safety, and infection control.
- \_\_\_ 4. **Form A (Certification of Completion of Education is required from all applicants):** 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 (CODA) of the American Dental Association (ADA) as set forth in 18VAC60-30-116 of the Regulations Governing the Practice of Dental Assistants. The school may use our form A or its own form to meet this requirement. The certification must bear the school's seal (if applicable), 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. **Applicants must submit a Form A for each degree and/or certificate earned from a dental program accredited by CODA.**  
**Documentation from foreign schools is not required and will not be considered.**  
Original document may be mailed by applicant/school or emailed directly from the school/agency official representative.
- \_\_\_ 5. **Official Transcript (required from all applicants):** 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. **Copies of transcripts, certificates and diplomas are not acceptable.** **Documentation from foreign schools is not required and will not be considered.**  
(Original official document may be mailed by applicant/school or emailed directly from the school/agency official representative. *An official transcript must be on original official school paper (sealed) or an online version that Board staff must download from the college, e-scrip or university website.*)
- \_\_\_ 6. **If applying by examination (Competency Examinations):** Verification of successful completion of the following examinations given by the accredited educational programs (may be listed on the official transcript or Form A):
  - a. A written examination at the conclusion of didactic coursework; and
  - b. A clinical competency exam.
- \_\_\_ 7. **If applying by endorsement (Form B Experience Verification):** 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 the qualifications were not substantially equivalent you can document experience in the restorative and prosthetic expanded duties set forth in 18VAC60-30-60 of the Regulations Governing the Practice of Dental Assistants for at least 24 of the past 48 months preceding application for registration in Virginia. You **must** submit **Form B**, which is to be completed by a supervising dentist(s), documenting your experience in the restorative and prosthetic expanded duties set forth in 18VAC60-30-60 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 June 14, 2023, began on June 15, 2019. The four calendar years for this example application are:

First year: June 15, 2019 to June 14, 2020;  
Second year: June 15, 2020 to June 14, 2021;  
Third year: June 15, 2021 to June 14, 2022, and;  
Fourth year: June 15, 2022 to June 14, 2023

- \_\_\_ 8. **Form C License/Registration Verification: Original** licensure status and certification from every jurisdiction in which you currently hold or have ever held a license/registration/certification to practice as a dental assistant **II** or as another health care professional. Copies of permits are not accepted. Certifications cannot be older than 6 months from date prepared. **Not disclosing all license/registration/certification ever held as a dental assistant II or as another health care professional, will result in your application being sent to Enforcement for an investigation.**

(Options: Mail to the Board (address listed on page 1) or have the issuing state official state representative email the verification directly to [bodlicensing@dhp.virginia.gov](mailto:bodlicensing@dhp.virginia.gov). If the issuing state/jurisdiction (agency) does not provide an original document, then the applicant must provide/submit the issuing agency statement as to why the issuing agency does not provide verification and submit a copy of the electronic version from the issuing agency website to the Board using either option.)

Documentation from foreign countries is not required and will not be considered.

- \_\_\_ 9. Please be aware that your signed 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 <http://www.dhp.virginia.gov/Boards/Dentistry/PractitionerResources/LawsRegulations/>.
- \_\_\_ 10. **Legal/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.
- \_\_\_ 11. **Address of Record and Publicly 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 publicly disclosable address. If you do not want your Address of Record to be made public, state law allows you to provide a second, publicly 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](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 of the date of your other certification of state licensure/registration, then you will be asked to submit a current state licensure certification before your application can be reviewed for approval.
- The Board does not have reciprocity with any other jurisdiction and cannot grant requests for exceptions to the policies, laws, or regulation nor predetermine acceptance of any documentation prior to the receipt of a complete application.

- Applicant will be notified by email of missing application items within approximately 15 business days from receipt of an application. Once your application is deemed complete, allow 30 business days processing time.
- To receive notice that your supporting documents have been delivered to the Board, it is suggested that the documents be mailed using FedEx or UPS with "Delivery Confirmation". **Mail sent by USPS is sent to a separate state processing facility that is offsite; therefore, mail can be delayed. Note: if you send something certified by USPS it only verifies that it got to the processing facility and not the Board.**
- **"Dental assistant II"** means a person under the direction and direct supervision of a dentist who is registered by the board to perform reversible, intraoral procedures as specified in 18VAC60-30-60 and 18VAC60-30-70.
- **"Dental assistant I"** means any unlicensed person under the direction of a dentist or a dental hygienist who renders assistance for services provided to the patient as authorized under this chapter but shall not include an individual serving in purely an administrative, secretarial, or clerical capacity.
- **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 or active licensure as a dental hygienist.
  - B. To be registered as a dental assistant II, a person shall complete a competency-based program from an educational institution that meets the requirements of [18VAC60-30-116](#) and includes all of the following:
    1. Didactic coursework in dental anatomy that includes basic histology, understanding of the periodontium and temporal mandibular joint, pulp tissue and nerve innervation, occlusion and function, muscles of mastication, and any other item related to the restorative dental process.
    2. Didactic coursework in operative dentistry to include materials used in direct and indirect restorative techniques, economy of motion, fulcrum techniques, tooth preparations, etch and bonding techniques and systems, and luting agents.
    3. Laboratory training to be completed in the following modules:
      - a. No less than 15 hours of placing, packing, carving, and polishing of amalgam restorations, placement of a non-epinephrine retraction cord, and pulp capping procedures and no less than six class I and six class II restorations completed on a manikin simulator to competency;
      - b. No less than 40 hours of placing and shaping composite resin restorations, placement of a non-epinephrine retraction cord, and pulp capping procedures, and no less than 12 class I, 12 class II, five class III, five class IV, and five class V restorations completed on a manikin simulator to competency; and
      - c. At least 10 hours of making final impressions, placement of a non-epinephrine retraction cord, final cementation of crowns and bridges after preparation, and adjustment and fitting by the dentist, and no less than four crown impressions, two placements of retraction cord, five crown cementations, and two bridge cementations on a manikin simulator to competency.
    4. Clinical experience applying the techniques learned in the preclinical coursework and laboratory training in the following modules:
      - a. At least 30 hours of placing, packing, carving, and polishing of amalgam restorations, placement of a non-epinephrine retraction cord, and no less than six class I and six class II restorations completed on a live patient to competency;
      - b. At least 60 hours of placing and shaping composite resin restorations, placement of a non-epinephrine retraction cord, and no less than six class I, six class II, five class III, three class IV, and five class V restorations completed on a live patient to competency; and
      - c. At least 30 hours of making final impressions ; placement of non-epinephrine retraction cord; final cementation of crowns and bridges after preparation, adjustment, and fitting by the dentist; and no less than four crown impressions, two placements of retraction cord, five crown cementations, and two bridge cementations on a live patient to competency.
    5. Successful completion of the following competency examinations given by the accredited educational programs:
      - a. A written examination at the conclusion of didactic coursework; and
      - b. A clinical competency exam.
  - C. An applicant may be registered as a dental assistant II with specified competencies set forth in subdivision a, b, or c of subdivisions B 3 and B 4 of this section.
- **18VAC60-30-140. Registration by endorsement as a dental assistant II.**
  - A. An applicant for registration by endorsement as a dental assistant II shall provide evidence of the following:
    1. Hold current certification as a Certified Dental Assistant (CDA) conferred by the Dental Assisting National Board or another national credentialing organization recognized by the American Dental Association;
    2. Be currently authorized to perform expanded duties as a dental assistant in each jurisdiction of the United States;
    3. 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 the qualifications were not substantially equivalent the dental assistant can document experience in the restorative and prosthetic expanded duties set forth in [18VAC60-30-60](#) for at least 24 of the past 48 months preceding application for registration in Virginia.
  - B. An applicant shall also:
    1. Be certified to be in good standing from each jurisdiction of the United States in which he is currently registered, certified, or credentialed or in which he has ever held a registration, certificate, or credential;
    2. Not have committed any act that would constitute a violation of § 54.1-2706 of the Code; and
    3. Attest to having read and understand and to remain current with the laws and the regulations governing dental practice in Virginia.

**18VAC60-30-60. Delegation to dental assistants II.**

Duties may only be delegated under the direction and direct supervision of a dentist to a dental assistant II who **has completed the coursework, corresponding module of laboratory training, corresponding module of clinical experience, and examinations specified in [18VAC60-30-120](#).**



9960 Mayland Drive, Suite 300  
 Henrico, Virginia 23233  
 (804) 367-4538 (Tel)  
 (804) 698-4266 (eFax)  
[bodlicensing@dhp.virginia.gov](mailto:bodlicensing@dhp.virginia.gov)  
[www.dhp.virginia.gov/dentistry](http://www.dhp.virginia.gov/dentistry)

**APPLICATION FOR REGISTRATION OF DENTAL ASSISTANT II**

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
Publicly 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. Are you relocating to Virginia or an adjoining state or the District of Columbia with a spouse who is 1) on federal active-duty orders, or 2) a veteran who has left active-duty service within one year of submission of this application? 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. 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 _____	_____	_____

**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	Expiration Date
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

5. Have you ever been dropped, suspended, expelled, or disciplined by any school or college for any cause whatever? If "YES", give details, schools(s), address(es) and date(s). Please note: the Board may ask for additional documentation. [ ] Yes [ ] No

\_\_\_\_\_  
 \_\_\_\_\_

6. Have you ever been denied a license/registration, or the privilege of taking a dental licensure/competency examination by a licensing authority? If "YES", give details, jurisdiction(s), and date(s) on a separate page. Please note: the Board may ask for additional documentation. [ ] Yes [ ] No

\_\_\_\_\_  
 \_\_\_\_\_

7. 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  
**"Additionally, any information concerning an arrest, charge, or conviction that has been sealed, including arrests, charges, or convictions for possession of marijuana, do not have to be disclosed."**

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. Please note: the Board may ask for additional documentation.

\_\_\_\_\_  
 \_\_\_\_\_

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8. 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 other health care facility, or any health care provider? If "YES", give details, jurisdiction(s), and date(s) on a separate page. Please note: the Board may ask for additional documentation. [ ] Yes [ ] No

\_\_\_\_\_

\_\_\_\_\_

9. Have you ever had any membership in a professional society revoked, suspended, or sanctioned in any manner? If "YES", give details, jurisdiction(s), and date(s) on a separate page. Please note: the Board may ask for additional documentation. [ ] Yes [ ] No

\_\_\_\_\_

\_\_\_\_\_

10. 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. Please note: the Board may ask for additional documentation. [ ] Yes [ ] No

\_\_\_\_\_

\_\_\_\_\_

11. 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. Please note: the Board may ask for additional documentation.

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. Do you have any reason to believe that you would pose a risk to the safety or well-being of your patients or clients? If "YES", please provide a full explanation and supporting documentation to the Board. Please note: the Board may ask for additional documentation. [ ] Yes [ ] No

\_\_\_\_\_

\_\_\_\_\_

2. Are you able to perform the essential functions of a practitioner in your area of practice with or without reasonable accommodation? If "NO", please provide a full explanation and supporting documentation to the Board. Please note: the Board may ask for additional documentation. [ ] Yes [ ] No

\_\_\_\_\_

\_\_\_\_\_

3. Have you ever been disciplined by any entity? If "YES", please provide a full explanation and supporting documentation to the Board. Please note: the Board may ask for additional documentation. [ ] Yes [ ] No

\_\_\_\_\_

\_\_\_\_\_

4. Have you ever had any conditions or restrictions been imposed upon you or your practice to avoid disciplinary action by any entity? If "YES", please provide a full explanation and supporting documentation to the Board. Please note: the Board may ask for additional documentation. [ ] Yes [ ] No

\_\_\_\_\_  
\_\_\_\_\_

**VIRGINIA BOARD OF DENTISTRY  
APPLICATION AFFIDAVIT**

I hereby certify that I am the person referred to in the forgoing application and the attached supporting documents and that the information on this application and in the attachments is true, complete, and correct to the best of my knowledge.

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 assistants. I hereby agree to abide by and remain current with the applicable laws and regulations which are available on <http://www.dhp.virginia.gov/Boards/Dentistry/PractitionerResources/LawsRegulations/>, and

I have attached a 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.

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

\_\_\_\_\_  
Date



**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 Program Coordinator of each School or Program which granted you a dental assisting degree or certificate.

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

**DEAN/PROGRAM COORDINATOR:** 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 (CODA) of the American Dental Association (ADA) **and** meets the Virginia Board of Dentistry educational programs requirements as stated in 18VAC60-30-116 of the regulations Governing the Practice of Dental Assistants. Please provide certification that the applicant named above successfully completed an expanded duties dental assisting program that includes didactic, laboratory and clinical 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/PROGRAM COORDINATOR:** 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.



**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 hereby 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 selected expanded didactic, laboratory and clinical duties on this form is true, complete, & correct:

**NOTE:** Duties may only be delegated under the direction and direct supervision of a dentist to a dental assistant II who has completed the coursework, corresponding module of laboratory training, corresponding module of clinical experience, and examinations specified in 18VAC60-30-120.

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 \_\_\_\_\_.

**SEAL/STAMP**

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

\_\_\_\_\_  
Print Name



**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/registration. 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 [bodlicensing@dhp.virginia.gov](mailto:bodlicensing@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 Type & # \_\_\_\_\_ 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 on \_\_\_\_\_  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