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 8, 2019 began on October 9, 2015. The four calendar years for this example application are:

- First year: October 9, 2015 to October 8, 2016;
- Second year: October 9, 2016 to October 8, 2017;
- Third year: October 9, 2017 to October 8, 2018, and;
- Fourth year: October 9, 2018 to October 8, 2019

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 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.
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*

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<th>First</th>
<th>Middle/Maiden</th>
<th>Suffix</th>
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Address of Record (Mailing Address)

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<th>City</th>
<th>State</th>
<th>Zip Code</th>
<th>Telephone Number</th>
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Publically Disclosable Address

<table>
<thead>
<tr>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
<th>Telephone Number</th>
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</thead>
</table>

Email Address:

Fax Number:

Date of Birth

Month   Day   Year

Social Security Number or Virginia 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. A. List in chronological order the dental assistant programs attended:

<table>
<thead>
<tr>
<th>Start Date &amp; Completion Date</th>
<th>Name of School/Program (ADA-CODA)</th>
<th>Degree/Certificate Awarded</th>
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B. Dental Assisting National Board Certification or other Dental Assistant Certification:

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<tr>
<th>Certification Number</th>
<th>Date Issued</th>
<th>Expiration Date</th>
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4. List all licenses/registrations/certificates, which you have been issued to practice as a dental assistant or as any other health care professional.

<table>
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<th>Jurisdiction</th>
<th>Number</th>
<th>Type</th>
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<th>Exp. Date</th>
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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). 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. [ ] Yes [ ] No

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.  

   ![Answer Options](Yes/No)

2. **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.  

   ![Answer Options](Yes/No)

3. **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.  

   ![Answer Options](Yes/No)

4. **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.  

   ![Answer Options](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?**  

   "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.  

   ![Answer Options](Yes/No)

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?**  

   "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.  

   ![Answer Options](Yes/No)

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?**  

   "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.  

   ![Answer Options](Yes/No)
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.

___________________________________________________________________________

___________________________________________________________________________
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/dentistry, 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

_________________________________________
Print Name
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.

_______________________________ 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.

_______________________________________________________________________________________

_______________________________________________________________________________________

_______________________________________________________________________________________

_______________________________________________________________________________________
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

SEAL/STAMP

_____________________________ 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. 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:
____________________________________________________________________________________________________________
____________________________________________________________________________________________________________
____________________________________________________________________________________________________________

______________________________________      ____________________________        ___________________  
Signature Title                Date

______________________________________
Print Name

SEAL