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 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 (Certification of Completed of Education):** 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. **Official Transcript:** 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. (May be mailed/emails to the Board. An official transcript must be on original official school paper (sealed) or an online version that Board staff must download from the college, e-crip or university website.)

6. **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 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

7. **Form C License 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 hygienist or as another health care professional. Copies of permits are not accepted. Certifications cannot be older than 6 months from date prepared. (May be mailed to the Board or emailed to the Board directly from the issuing state official representative.)
8. 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 www.dhp.virginia.gov/dentistry.

9. 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.

10. 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 section to which it relates, sign the page and enclose it with the application.

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

<table>
<thead>
<tr>
<th>Name: Last*</th>
<th>First</th>
<th>Middle/Maiden</th>
<th>Suffix</th>
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<tbody>
<tr>
<td>Address of Record (Mailing Address)</td>
<td>City</td>
<td>State</td>
<td>Zip Code</td>
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<tr>
<td>Publicly Disclosable Address</td>
<td>City</td>
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<td>Zip Code</td>
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<tr>
<td>Email Address:</td>
<td>Fax Number:</td>
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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

<table>
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<tr>
<th>FEE AMOUNT</th>
<th>APPLICANT #</th>
<th>REGISTRATION #</th>
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<tr>
<td>Certification of Education/Form B</td>
<td>DANB Certification</td>
<td>Date Issued</td>
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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 [ ] Yes [ ] No
   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.
2. Are you active-duty military? If “YES”, include a copy of your official military orders with the [ ] Yes [ ] No
   application.
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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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?

   “Currently” means recently enough so that the condition could reasonably have an impact on your ability to function as 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.

   [ ] 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.

   [ ] 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

   [ ] 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.

___________________________________________________________________________
___________________________________________________________________________

[  ] Yes  [  ] No

VIRGINIA BOARD OF DENTISTRY
APPLICATION AFFIDAVIT

I hereby certify that I am the person referred to in the foregoing 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 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 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 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 ________/________/________

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.

<table>
<thead>
<tr>
<th>I am making application for registration in Virginia by:</th>
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<tbody>
<tr>
<td>[ ] Examination for Dental Assistant II</td>
</tr>
<tr>
<td>[ ] Endorsement for Dental Assistant II</td>
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</table>

I, was granted License/Registration Number ____________________, on _________________________________ by the 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.

<table>
<thead>
<tr>
<th>Applicant’s Signature</th>
<th>Applicant’s Typed/Printed Name</th>
<th>Applicant’s Address</th>
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<thead>
<tr>
<th>Executive Officer of the Board: please send this form directly to the Virginia Board of Dentistry.</th>
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<tbody>
<tr>
<td>State of ___________________________________________</td>
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<td>Graduate of _________________________________________</td>
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</table>

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