

# APPLICATION FOR REINSTATEMENT OF QUALIFICATION IN DENTAL RADIOGRAPHY

## IOWA DENTAL BOARD

400 S.W. 8<sup>th</sup> Street, Suite D, Des Moines, Iowa 50309-4687;  
Ph. (515) 281-5157; <http://www.dentalboard.iowa.gov>

Complete each question; if not applicable, mark "n/a." Submit the **non-refundable** application fee of **\$100** with this application. Before completing this application, please read the instructions on page 4 of this application.

### 1. Identifying Information

Full Legal Name: (First, Middle, Last)					
Other Last Names Used: (e.g. Maiden, or other married names)			Email Address:		
Home Address:					
City:	County:	State:	Zip Code:		
Work Address:					Work Email:
City:	County:	State:	Zip Code:		
Home Phone:	Home Fax:	Work Phone:	Work Fax:		
Social Security Number:	<b>Privacy Act Notice:</b> Disclosure of your Social Security Number on this license application is required by 42 U.S.C. § 666(a)(13), Iowa Code §§ 272J.8(1) and 261.126(1), and Iowa Code § 272D.8(1). The number will be used in connection with the collection of child support obligations, college student loan obligations, and debts owed to the state of Iowa, and as an internal means to accurately identify licensees, and may also be shared with taxing authorities as allowed by law including Iowa Code § 421.18.				
Height:	Weight:	Hair Color:	Eye Color:		
Identifying Marks:	Gender: Female: <input type="checkbox"/> Male: <input type="checkbox"/>	U.S. Citizen: Yes: <input type="checkbox"/> No: <input type="checkbox"/>	If no, Visa Type or Alien Registration Number:		
Date of Birth:	City of Birth:	State of Birth:	Country of Birth:		
Father's Full Name:		Mother's Full Name:			
Full Name & Address of Nearest Relative Not Living With You:					
Name of High School:	City:	State:	From: (Mo, Yr)	To: (Mo, Yr)	Diploma <input type="checkbox"/> GED <input type="checkbox"/>
Name of College:	City:	State:	From: (Mo, Yr)	To: (Mo, Yr)	Type of Degree:

### 2. Reinstatement Information

Qualification Number: \_\_\_\_\_ Original Issue Date: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

#### YES NO

- A. Are you currently registered as a dental assistant or on trainee status? If yes, provide registration or trainee number: \_\_\_\_\_
- B. Are you currently licensed by the Iowa Board of Nursing? If yes, provide license number: \_\_\_\_\_  
**Please attach proof of current licensure with the Iowa Board of Nursing.**

Office Use:	Qualification #:	Date Issued:	Fee:	Exam:	Course:
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Last updated July 2008

**YES NO**

- C. Are you registered, certified, or qualified as a dental assistant in another state? If yes, which state(s), and type of qualification: \_\_\_\_\_  
\*request written verification from each state.
- D. Have you completed two hours of continuing education in the area of dental radiography\*\*?  
Date of Course: \_\_\_\_\_ Course Sponsor: \_\_\_\_\_  
**Must attach proof.** (\*\* Two hours continuing education is required of those whose qualification in radiography lapsed less than 4 years ago.)
- E. Have you successfully completed a written examination for Qualification in Dental Radiography?  
(Note: See instruction #4 on page 4.) Date of Examination: \_\_\_\_\_  
Location: \_\_\_\_\_

**3. Definitions****Important! Read these definitions before completing the following questions.**

**“Medical Condition”** means any physiological, mental, or psychological condition, impairment, or disorder, including drug addiction and alcoholism.

**“Chemical Substances”** means alcohol, legal and illegal drugs, or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber’s direction, as well as those used illegally.

**“Currently”** does not mean on the day of, or even in weeks or months preceding the completion of this application. Rather, it means recently enough so that the use of chemical substances or medical conditions may have an ongoing impact on the ability to function and practice, or has adversely affected the ability to function and practice within the past (2) two years.

**“Improper use of drugs or other chemical substances”** means ALL of the following:

1. The use of any controlled drug, legend drug, or other chemical substance for any purpose other than as directed by a licensed health care practitioner; and
2. The use of any substance, including but not limited to, petroleum products, adhesive products, nitrous oxide, and other chemical substances for mood enhancement.

**“Illegal use of drugs or other chemical substances”** means the manufacture, possession, or use of any chemical substance prohibited by law.

**SECTION 4.** In answering each of the following questions, please check the appropriate box next to each question. **FOR EACH “YES” ANSWER TO QUESTIONS 1 THROUGH 14, YOU MUST PROVIDE A SEPARATE, SIGNED STATEMENT GIVING FULL DETAILS, INCLUDING DATE(S), LOCATION(S), ACTION(S), ORGANIZATION(S) OR PARTIES INVOLVED, AND SPECIFIC REASON(S).**

**YES NO**

1. Do you currently have a medical condition which in any way impairs or limits your ability to practice dental radiography with reasonable skill and safety?
2. Are you currently engaged in the illegal or improper use of drugs or other chemical substances?
3. Do you currently use alcohol, drugs, or other chemical substances that would in any way impair or limit your ability to practice dental radiography with reasonable skill and safety?
4. Are you receiving ongoing treatment or participation in a monitoring program that reduces or eliminates the limitations or impairments caused by either your medical condition or use of alcohol, drugs, or other chemical substances?
5. Except for minor speeding or parking offenses, have you ever been arrested, charged, convicted, found guilty of, or entered a plea of guilty or no contest to a felony or misdemeanor crime or offense, including actions that resulted in a deferred or expunged judgment?

Name of Applicant \_\_\_\_\_

**YES NO**

- 6. Have you ever been terminated or requested to withdraw from any dental assisting school or training program?
- 7. Have you ever received a warning, reprimand, or been placed on probation during a dental assisting training program or school?
- 8. Have you ever been denied a certificate/registration to practice dental radiography or dental assisting?
- 9. Have you ever voluntarily surrendered a certificate/registration issued to you by any professional licensing agency?
- 10. If yes, was disciplinary action pending against you, or were you under investigation by a licensing agency at the time the voluntary surrender of certificate/registration was tendered?
- 11. Have any judgments been entered against you resulting from your practice of dental radiography?
- 12. Are charges or an investigation currently pending relative to your dental radiography or dental assisting certificate/registration in any other state?
- 13. Has any jurisdiction of the United States or other nation ever limited, restricted, warned, censured, placed on probation, suspended, or revoked a certificate/registration you held?
- 14. Have you ever been notified of any charges filed against you by a licensing or disciplinary agency or any jurisdiction of the U.S. or other nation?
- 15. Do you understand that if a qualification is granted by this Board, it will be based in part on the truth of the statements contained herein, which, if false, may subject you to criminal prosecution and revocation of the qualification?

**5. Dental Assisting Employment**

Provide a chronological listing of all dental related employment since you first obtained your radiology qualification. Include months, years, location (city & state), and type of work. Attach a separate sheet if necessary.

Employer Dentist Name & Location	Type of Work (e.g. Chairside, Lab, Office)	From:(Mo, Yr)	To:(Mo, Yr)	Hours per Week:

**6. Briefly state the reason for seeking reinstatement and why your radiography qualification was not maintained:**

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Name of Applicant \_\_\_\_\_

### 7. Affidavit of Applicant

STATE OF \_\_\_\_\_ COUNTY OF \_\_\_\_\_

I, \_\_\_\_\_, hereby declare under penalty of perjury that I am the person described and identified in this application. I also declare, under penalty of perjury, that if I did not personally complete the foregoing application that I have fully read and confirmed each question and accompanying answer, and take full responsibility for all answers contained in this application.

If dental radiography qualification is issued to me, I understand that if I violate rules or regulations, my qualification may be revoked as provided by law. I declare under penalty of perjury that my answers and all statements made by me on this application are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for denial, suspension, or revocation of my registration and/or radiography qualification.

I hereby authorize the Iowa Dental Board and/or its agents to verify any information including, but not limited to, criminal history and motor vehicle driving records. I authorize all colleges or universities, employers and law enforcement agencies to release any information concerning my background to the Iowa Dental Board for radiography qualification purposes. I do hereby release said person(s) from any and all liability that may be incurred as a result of furnishing such information. A photocopy of this release form will be valid as an original thereof, even though the said photocopy does not contain an original writing of my signature.

Signed (full name) \_\_\_\_\_

Sworn to before me this \_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_

Notary Public \_\_\_\_\_ My Commission Expires: \_\_\_\_\_

### INSTRUCTIONS

1. Applicants must complete each question on the application and return to the Board office at the address on this form. If not applicable, mark "NA." Applications must be typewritten or printed legibly in ink.
2. The application must be notarized in section 7, Affidavit of Applicant.
3. Applicants whose qualifications in dental radiography have lapsed less than four years ago must attach proof of two hours of continuing education in the subject area of dental radiography, taken within the previous two-year period.
4. If your radiography qualification has been lapsed for more than four years, you are required to retake and successfully complete the Board radiography examination OR Dental Assisting National Board (DANB) CDA or Dental Radiation Health & Safety examination. However, a dental assistant who presents proof of current radiography qualification in another state and who has engaged in dental radiography in that state is exempt from the examination requirement.
5. Request that verification of your registration or radiography qualification be sent directly to the Iowa Board from each state in which you are registered, licensed, or qualified in dental assisting.
6. If you are a nurse licensed by the Iowa Board of Nursing, be sure to attach proof of current licensure.
7. Applicants should promptly inform the Board of all address/name changes, and employment changes.
8. You must include the reinstatement fee of **\$100**. ***This fee is non-refundable.*** Make check payable to: Iowa Dental Board.