Iowa Dental Board

Documentation of Training for Delegable Procedures to Expanded Function Dental Assistants

Name: ______________________________ Work Address: ______________________________

Certified with the Dental Assisting National Board: Yes ☐ No ☐ If yes, date: ____________________

Have a minimum of two years experience in clinical dental assisting: Yes ☐ No ☐ From: __________ to __________

Delegable Procedure	Review of Educational Material	Training Observation	Supervised Application M= model P= patient	Date Training Completed	Postcourse Assessment Pass/Fail	Signature of Trainee	Signature of Dentist
Taking Occlusal Registrations							
Placement & Removal of Gingival Retraction							
Taking Final Impressions							
Fabrication and Removal of Provisional Restorations							
Applying Cavity Liners and Bases, Desensitizing Agents and Bonding Systems							
Placement & Removal of Dry Socket Medication							
Placement of Periodontal Dressings							
Testing Pulp Vitality							
Monitoring of Nitrous Oxide Inhalation Analgesia							