STATE OF IOWA
IOWA DENTAL BOARD

TERRY E. BRANSTAD, GOVERNOR
KIM REYNOLDS, LT. GOVERNOR

JILL STUECKER
EXECUTIVE DIRECTOR

Iowa Dental Assistant Registration & Dental Radiography Qualification Application

Application Form and Fee

Please find enclosed the application for dental assistant registration and radiography qualification. When completing this application, please be advised of the following:

- The application fee is non-refundable. If you are applying for registration only, the fee is $40. If you are applying for registration *and* a qualification in dental radiography, the fee is $60. Do not submit payment in cash.
- For specific registration requirements, please refer to the Board's rules at Iowa Administrative Code 650—Chapter 20. For specific requirements for obtaining a qualification in dental radiography, please refer to Iowa Administrative Code 650—Chapter 22.
- Type or legibly print all information requested in the application. Complete all questions. If not applicable, please mark sections 'N/A'.
- If you are making application for qualification in dental radiography, be sure to answer "yes" to question 4, on page 1 of the application. If you were a dental assistant trainee in Iowa, make sure that the supervising dentist verifies your training in dental radiography on the affidavit of employment.
- Please allow a minimum of 14 days for your application to be processed. The Board office will contact you if additional information is required to complete your application.
- Registrations are issued administratively following review of a completed application and all required documentation, unless the application warrants referral to the Licensure/Registration Committee, the full Board, or unless a personal appearance is required.
- Applications are valid for only 180 days from the date of receipt. If the application has not been completed within 180 days, a new application and fee will have to be submitted if you wish to obtain an Iowa dental assistant registration and qualification in dental radiography.
- **Failure to answer all questions completely or accurately, and/or omission or falsification of material facts may be cause for denial of your application, or disciplinary action if you are subsequently registered by the Board.**
- **Please note:** If you are a nurse, licensed in Iowa, applying for a qualification in dental radiography, please be sure to complete the application for qualification in dental radiography. As a licensed nurse, you are not required to obtain registration as a dental assistant.

Basis of Application

In order to qualify for registration in Iowa, you must have met one of the following requirements for training and education:

- ❑ Have completed a minimum of six months of training, under dental assistant trainee status in Iowa within 12 months of the first date of employment as a dental assistant;
- ❑ Have at least six months experience within the past two years working as a dental assistant in another state; or
- ❑ Have completed a post-secondary program in dental assisting through an ADA-accredited dental assisting program.

Public Information

All or part of the information provided on the application form may be considered a public record under Iowa Code Chapter 22 and Iowa Administrative Code 650—Chapter 6. Information about misconduct and examination results may not be subject to disclosure.

Disclosure of Medical Conditions, Criminal History and Disciplinary Actions
Be advised that the application for dental assistant registration asks about any medical conditions you have that might impair your ability to practice the profession. The Board also considers any prior criminal history and disciplinary actions when issuing dental assistant registrations. As part of the application process you will be asked questions about prior criminal history and disciplinary action.

If you have any questions concerning these requirements, please notify the Board office. If any of these situations pertain to you, there may be delays at the time of registration. We suggest you contact the Board office for information as to what documentation may be necessary for registration. Contacting the Board office about any of these situations may avoid unnecessary delays at the time of registration.

Examinations
You must successfully complete a Board-approved course of study and examinations in the areas of infection control/ hazardous materials and jurisprudence. If you have taken the DANB CDA or ICE examinations after June 1991, you may not need to pass a separate state examination in infection control and hazardous materials. You may complete the required examinations at a number of local community colleges. A list of testing sites is available at http://www.dentalboard.iowa.gov/forms/docs/TestingSites.pdf.

To gain admission to the testing sites, you will need a Board authorization letter to sit for the examinations and photo identification. If you are a dental assistant trainee, bring your authorization letter. If you are applying for registration based on prior dental assisting experience out of state, please contact the Board in writing for an authorization allowing you to test.

Dental Radiography
If you intend to apply for a qualification in dental radiography, you must have completed Board-approved training and a Board-approved examination as required by Iowa Administrative Code 650—Chapter 22. If you do not apply for a qualification in dental radiography at this time, you must make application within two years of having completed Board-approved training in the area of dental radiography; or you will be required to complete a formal course of study in dental radiography if you wish to obtain a qualification in dental radiography in Iowa.

Military Service & Veterans Preference: Pursuant to the 2014 Home Base Iowa Act, if you are currently serving in the military or are a veteran, you may be eligible to request credit towards licensure for verified military education, training, or service toward licensing experience or education requirements by submitting a (separate) military service application form to the Board office. Please contact Board staff at 515-281-5157 for further information or to obtain military service application form.

Veterans who have a fully completed application for licensure will be given priority and will be expedited. Veterans who hold an unrestricted professional license in another jurisdiction may be eligible for licensure through reciprocity.

Military Service: "Military service" means honorably serving on federal active duty, state active duty, or national guard duty, as defined in Iowa Code section 29A.1, in the military services of other states, as provided in 10 U.S.C. section 101(c), or in the organized reserves of the United States, as provided in 10 U.S.C. section 10101.

Veteran: A "veteran" means an individual who meets the definition of "veteran" in Iowa Code section 35.1(2).

Spouse of Veteran: A "spouse of a veteran" means a spouse of a qualified veteran.

On-The-Job Training Manual Available
The Board has approved an on-the-job training manual. The trainee manual is available through the Board office for $70. To order a manual, submit a request in writing along with the $70 fee for each manual requested. Do not submit payment in cash.

Application Checklist

☐	Application completely filled out; all questions answered.
☐	Application fee paid. (Registration only: $40; **OR** Registration *and* radiography qualification: $60)
☐	Applicant is one of the following (check one): ____ A Dental Asst. Trainee OR currently a Registered Dental Asst. ____ A graduate of an accredited dental assisting program
☐	Affidavit of Applicant
☐	Completed statement confirming that you hold a valid certification in CPR from a nationally-recognized sponsor including a "hands-on" component. (Online certification is not accepted.)
☐	Statement indicating that you are a high school graduate, or equivalent (e.g. GED).
☐	Completed examinations: ___ Infection control/hazardous materials ___ Jurisprudence ___ Dental radiography, if seeking a qualification in dental radiography
☐	Affidavit of Employment or Certification of Education (from an ADA-accredited school, signed & dated, w/school seal)
☐	If registered, certified or qualified as a dental assistant in another state – written verification from each state.
☐	Copy of examination scores or statement of Dental Assisting National Board (DANB) with resulting scores of all examinations completed.
☐	Notarized copy of marriage certificate or divorce decree (if applicant's name is different on documentation)
	Qualification in Dental Radiography
☐	If applying for a qualification in dental radiography, applicant has completed (within the past 2 yrs.) course of study in dental radiography (check one): ____ On the job while under Dental Assistant Trainee status ____ Graduate of a course at post-secondary school ____ Graduate of another program prior-approved by Board

Testing Sites:
A list of testing sites is available at http://www.dentalboard.iowa.gov/Forms/TestingSites.pdf.

Contact Us: If you have any questions, or need further assistance, please feel free to contact Janet Arjes at (515) 281-3248 or janet.arjes@iowa.gov.

Board website: www.dentalboard.iowa.gov.

APPLICATION FOR IOWA DENTAL ASSISTANT REGISTRATION & DENTAL RADIOGRAPHY QUALIFICATION

IOWA DENTAL BOARD

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

This form must be completed and returned to the Iowa Dental Board. Include the *non-refundable* application fee. Do not submit payment in cash. Complete each question on the application. If not applicable, mark "N/A."

Select one of the following:

☐ **Applying for RDA** (WITHOUT radiography qualification) – Fee: $40
An RDA is a registered dental assistant WITHOUT a radiography qualification.

☐ **Applying for QDA** (WITH radiography qualification) – Fee: $60
A QDA is a registered dental assistant WITH a radiography qualification.

Full Legal Name: (First, Middle, Last)			
Other Last Names Used: (e.g. maiden name, other married names)		Email Address:	
Home Address:		Home Phone	
City:	County:	State:	Zip Code:
Date of Birth:	Gender: ☐ Female ☐ Male	Are you a US Citizen: ☐ Yes ☐ No	**If no, visa type or alien registration number:** ☐ Student Visa ☐ Work Visa ☐ Alien Registration **Provide visa or alien registration number:** **If visa, provide expiration date of current visa:**
Social Security #:	**Privacy Act Notice:** Disclosure of your Social Security Number on this registration 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 registrations, and may also be shared with taxing authorities as allowed by law including Iowa Code § 421.18.		
City of Birth:		State of Birth:	Country of Birth:
Work Address:		Work Phone:	Work Fax:
City:	State:	Zip:	Work Email:
Are you currently serving in the military? ☐ Yes ☐ No	**Are you a Veteran?** ☐ Yes ☐ No	**Are you the spouse of a Veteran?** ☐ Yes ☐ No	

Currently certified in CPR: ☐ Yes ☐ No	Exp. Date of CPR Certification:	
Did you work as a dental assistant trainee in Iowa? ☐ Yes ☐ No		If yes, please complete the Affidavit of Employment.
Did you work as a dental assistant in another state for a minimum of 6 months in the last 2 years? ☐ Yes ☐ No	If yes, in what state(s) did you practice dental assisting?	If yes, please complete the Affidavit of Employment.
Are you certified through DANB? ☐ Yes ☐ No	If yes, in what year was your DANB certification issued?	If yes, please provide a copy of your DANB exam scores.

For office use only:	**Fee:**	**Registration #:**	**Date Issued:**

Name of Applicant: _____

DENTAL RADIOGRAPHY (QDA APPLICANTS ONLY)

Have you completed Board-approved training in dental radiography within the last 2 years?* ☐ Yes ☐ No	If yes, are you also applying for a qualification in dental radiography? ☐ Yes ☐ No	If yes, on what date was your training completed?
Do you now hold, or have you ever held a qualification in dental radiography issued by the Iowa Dental Board? ☐ Yes ☐ No	If yes, what is the qualification number?	If you held a radiography qualification, *which is currently lapsed*, contact the Board for information about how to reinstate your radiography qualification.

*If training in dental radiography was completed in another state, please contact the Board office for further information.

EDUCATION

High School Name:	High School City/State:	From (Mo/Yr):	To (Mo/Yr):	☐ Diploma ☐ GED Date:
College Name:	College City/State:	From (Mo/Yr):	To (Mo/Yr):	Degree:

Are you a current DA program student? ☐ Yes ☐ No	If yes, please provide name of program.	Are you a DA program graduate? ☐ Yes ☐ No	If a graduate, please list date of graduation.

PRACTICE INFORMATION

Primary Practice Setting: ☐ Educational ☐ Group ☐ Military ☐ Public Health ☐ Solo ☐ Other:	Practice at more than 1 location? ☐ Yes ☐ No If yes, where:	**Practice Status:** ☐ Full Time ☐ New Applicant ☐ Not Practicing ☐ Part Time ☐ Temporarily Inactive ☐ Retired

EXAMINATION INFORMATION

Infection Control:	Successfully passed: ☐ Yes ☐ No	Date Completed:	Did you complete remedial education in infection control? ☐ Yes ☐ No If yes, date:
Jurisprudence:	Successfully passed: ☐ Yes ☐ No	Date Completed:	Did you complete remedial education in jurisprudence? ☐ Yes ☐ No If yes, date:
Dental Radiography:	Successfully passed: ☐ Yes ☐ No	Date Completed:	Did you complete remedial education in dental radiography? ☐ Yes ☐ No If yes, date:
DANB Examinations:*	Successfully passed: ☐ Yes ☐ No	Date Completed:	If yes, please list DANB examinations completed. Please forward copy of scores.

*DANB Infection Control Examination (ICE) is accepted if completed after June 1991. DANB Radiation Safety examination is accepted if completed after January 1986.

OUT-OF-STATE PRACTICE AS DENTAL ASSISTANT

List all states in which you have practiced as a dental assistant. In cases where registration is required in a state in which you practiced, you will be required to request written certification of registration(s) held.

State:	Was registration required to practice as a dental assistant?	If yes, registration number:	If yes, date issued:
	☐ Yes ☐ No		
	☐ Yes ☐ No		
	☐ Yes ☐ No		

Name of Applicant: _____

CHRONOLOGY OF ACTIVITIES

Provide a chronological listing of all dental-related employment in the last 3 years, or since you graduated from dental assisting school. Include months, years, location (city & state), and type of practice. Attach additional sheets of paper, if necessary, signed by you.

Employer Dentist Name & Location	**Type of Work** (e.g. chairside, lab, office)	**From (Mo/Yr):**	**To (Mo/Yr):**	**Avg. Hours per Week**

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 two (2) years.

"Improper use of drugs or other chemical substances" means ANY 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, distribution, or use of any drug or chemical substance prohibited by law.

Name of Applicant: _____

PERSONAL & CONFIDENTIAL DATA

In answering each of the following questions, please check the appropriate box next to each question. **FOR EACH "YES" ANSWER TO QUESTIONS 1 THROUGH 15, YOU MUST PROVIDE A 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 that in any way impairs or limits your ability to practice dental assisting with reasonable skill and safety?
Yes ☐	**No** ☐	2. Are you currently engaged in the illegal or improper use of drugs or other chemical substances?
Yes ☐	**No** ☐	3. Do you currently use alcohol, drugs, or other chemical substances that would in any way impair or limit your ability to practice dental assisting with reasonable skill and safety?
Yes ☐	**No** ☐	4. If yes to questions 1 to 3, are you receiving ongoing treatment or participating 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?

If you answered yes to any of the questions above, please provide a signed and dated statement below providing the details as requested in the instructions above. Please add a separate sheet of paper if necessary.

_____

_____

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_____ _____

Signature **Date**

Name of Applicant: _____

In answering each of the following questions, please check the appropriate box next to each question. **FOR EACH "YES" ANSWER TO QUESTIONS 1 THROUGH 15, YOU MUST PROVIDE A SIGNED STATEMENT GIVING FULL DETAILS, INCLUDING DATE(S), LOCATION(S), ACTION(S), ORGANIZATION(S) OR PARTIES INVOLVED, AND SPECIFIC REASON(S).**		
Yes ☐	**No** ☐	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?
Yes ☐	**No** ☐	6. Have you ever been terminated or requested to withdraw from any dental assisting school or training program?
Yes ☐	**No** ☐	7. Have you ever been requested to repeat a portion of any dental assisting training program/school?
Yes ☐	**No** ☐	8. Have you ever received a warning, reprimand, or been placed on probation during a dental assisting training program/school?
Yes ☐	**No** ☐	9. Have you ever been denied a registration/certificate to practice dental assisting?
Yes ☐	**No** ☐	10. Have you ever voluntarily surrendered a registration/certification issued to you by any professional licensing agency?
Yes ☐	**No** ☐	11. If yes, was license/registration disciplinary action pending against you, or were you under investigation by a licensing agency at the time the voluntary surrender of license/registration was tendered?
Yes ☐	**No** ☐	12. Have any settlement agreements been rendered or any judgments entered against you resulting from your practice of dental assisting?
Yes ☐	**No** ☐	13. Are charges or an investigation currently pending relative to your license/registration in any other state?
Yes ☐	**No** ☐	14. Has any jurisdiction of the United States or other nation ever limited, restricted, warned, censured, placed on probation, suspended, or revoked a license/registration you held?
Yes ☐	**No** ☐	15. Have you ever been notified of any charges filed against you by a licensing or disciplinary agency of any jurisdiction of the U.S. or other nation?
Yes ☐	**No** ☐	**16.** I certify that I am at least 17 years of age and am a high school graduate or equivalent.
Yes ☐	**No** ☐	**17.** Do you understand that if registration 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 registration?

Name of Applicant: _____

AFFIDAVIT OF APPLICANT

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 registration is issued to me, I understand that if I violate state law, my registration 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 or have substantial omission in this application, I hereby agree that such act shall constitute cause for denial, suspension, or revocation of my registration.

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 registration 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.

Signature of Applicant _____ Date _____

APPLICATION ACKNOWLEDGEMENTS

☐ **FEES**

Pursuant to Iowa Administrative Code 650—Chapter 15, application fees are non-refundable.

☐ **PUBLIC RECORDS**

All or part of the information provided on the application form may be considered a public record under Iowa Code chapter 22 and Iowa Administrative Code 650—Chapter 6. Information on misconduct and examination results is not subject to disclosure. Criminal history may be subject to disclosure.

☐ **APPLICATIONS**

Registrations are issued administratively following review of a completed application and all required credentials, unless the application warrants referral to the Licensure/Registration Committee, the full Board, or unless a personal appearance is required.

Applications are valid for only 180 days from the date of receipt. If the application has not been completed within 180 days, a new application and fee will have to be submitted if you wish to obtain a registration in Iowa.

☐ **CPR ACKNOWLEDGEMENT**

I hereby declare that I possess a valid certificate from a nationally-recognized course in CPR that includes a "hands-on" clinical component. I acknowledge that proof of certification will be maintained and made available to the Board upon request.

I hereby declare that I acknowledge the statements above concerning fees, public records, applications and CPR.

Signature: _____ Date: _____

CERTIFICATION OF DENTAL ASSISTING EDUCATION

As part of the application process, the Iowa Dental Board requires that the school at which the applicant received her/his dental assisting education complete this form. The completed form must be mailed directly from the school to the **IOWA DENTAL BOARD.** The applicant's signature authorizes release of information, favorable or otherwise, directly to the Board.

Print Name: _____ **Date of Birth or Last 4 of SSN: _____**

Signature: _____ **Date: _____**

****

This portion of the form should be completed by the school.

IT IS HEREBY CERTIFIED THAT _____
(Name of Applicant)

RECEIVED DENTAL ASSISTING EDUCATION AT_____
(Name of School)

LOCATED AT_____
(Full Address of School)

GRANTED A DEGREE IN DENTAL ASSISTING ON _____
(Month/Day/Year)

Was the school accredited by the Commission on Dental Accreditation of the American Dental Association at the time the applicant graduated? **Yes _____** **No _____**

Did the student ever receive a warning, reprimand?* **Yes _____** **No _____**

Was the student placed on probation or disciplined?* **Yes _____** **No _____**

***If yes, please provide details concerning the action taken.**

President, Dean, Secretary, or Registrar:

Print Name_____ **Title_____**

Signature_____ **Date_____**

Phone #_____ **Email_____**

SCHOOL SEAL

Return completed form to:
IOWA DENTAL BOARD
400 S.W. 8th St, Suite D
Des Moines, IA 50309-4687
Phone (515) 281-5157
Janet.Arjes@iowa.gov **

**This original certification must still be sent via mail to include the school seal.

AFFIDAVIT OF EMPLOYMENT

The dental assistant's supervising dentist should complete this form.

Applicants for dental assistant registration who are not graduates of a ADA-accredited postsecondary dental assisting program must either (1) work in a dental office for a minimum of six months as a dental assistant trainee, within 12 months of the first date of employment, or (2) have had at least six months of prior dental assisting experience under the supervision of a licensed dentist within the past two years. To verify that the dental assistant meets one of these requirements, the supervising dentist must complete and sign the following form.

I hereby certify that the applicant, _____, has successfully completed didactic and clinical training and has worked as a dental assistant under my supervision on the following dates at the following locations:

Dates: **Location(s)**:
From (MM/DD/YYYY): To: (MM/DD/YYYY)

_____

_____

_____

YES ☐ **NO** ☐ I further certify that the applicant has received Board-approved clinical training in dental radiography within the last two (2) years and has exhibited clinical proficiency in the area of dental radiography.

_____ _____
Printed Name of Dentist License #

_____ _____
Dentist's Signature Date

Return completed form to:
IOWA DENTAL BOARD
400 S.W. 8th St, Suite D
Des Moines, IA 50309-4687
Phone (515) 281-5157