

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 Assisting National Board (DANB) or another certification from a credentialing organization recognized by the American Dental Association (ADA) and acceptable to the board, which was granted following passage of an examination on general chairside assisting, radiation health and safety, and infection control.
- _____ 4. **Form A (Certification of Completed of Education is required from all applicants):** 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 (CODA) of the American Dental Association (ADA) as set forth in 18VAC60-30-1116 of the Regulations Governing the Practice of Dental Assistants. 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 (if applicable), 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 (required from all applicants):** 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 mail/email 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-scrip or university website.)*
- _____ 6. **If applying by examination (Competency Examinations):** Verification of successful completion of the following examinations given by the accredited educational programs (may be listed on the official transcript):
 - a. A written examination at the conclusion of didactic coursework; and
 - b. A clinical competency exam.
- _____ 7. **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 the qualifications were not substantially equivalent you can document experience in the restorative and prosthetic expanded duties set forth in 18VAC60-30-60 of the Regulations Governing the Practice of Dental Assistants for at least 24 of the past 48 months preceding application for registration in Virginia. You **must** submit **Form B**, which is to be completed by a supervising dentist(s), documenting your experience in the restorative and prosthetic expanded duties set forth in 18VAC60-30-60 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, 2020 began on October 9, 2016. The four calendar years for this example application are:

First year: October 9, 2016 to October 8, 2017;
Second year: October 9, 2017 to October 8, 2018;
Third year: October 9, 2018 to October 8, 2019, and;
Fourth year: October 9, 2019 to October 8, 2020

- _____ 8. **Form C License/Registration 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 dentistry or as another health care professional. Copies of permits are not accepted. Certifications cannot be older than 6 months from date prepared. (May be mail to the Board or emailed to the Board directly from the issuing state official representative. If the issuing state/jurisdiction (agency) does not provide an original document then the applicant must provide/submit the issuing agency statement as to why the issuing agency does not provide verification and submit a copy of the electronic version from the issuing agency website to the Board.)
- _____ 9. 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.
- _____ 10. **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.
- _____ 11. **Address of Record and Publicly 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.
- **"Dental assistant II"** means a person under the direction and direct supervision of a dentist who is registered by the board to perform reversible, intraoral procedures as specified in 18VAC60-30-60 and 18VAC60-30-70.
- **"Dental assistant I"** means any unlicensed person under the direction of a dentist or a dental hygienist who renders assistance for services provided to the patient as authorized under this chapter but shall not include an individual serving in purely an administrative, secretarial, or clerical capacity.
- **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 or active licensure as a dental hygienist.
 - B. To be registered as a dental assistant II, a person shall complete a competency-based program from an educational institution that meets the requirements of [18VAC60-30-116](#) and includes all of the following:

1. Didactic coursework in dental anatomy that includes basic histology, understanding of the periodontium and temporal mandibular joint, pulp tissue and nerve innervation, occlusion and function, muscles of mastication, and any other item related to the restorative dental process.
 2. Didactic coursework in operative dentistry to include materials used in direct and indirect restorative techniques, economy of motion, fulcrum techniques, tooth preparations, etch and bonding techniques and systems, and luting agents.
 3. Laboratory training to be completed in the following modules:
 - a. No less than 15 hours of placing, packing, carving, and polishing of amalgam restorations, placement of a non-epinephrine retraction cord, and pulp capping procedures and no less than six class I and six class II restorations completed on a manikin simulator to competency;
 - b. No less than 40 hours of placing and shaping composite resin restorations, placement of a non-epinephrine retraction cord, and pulp capping procedures, and no less than 12 class I, 12 class II, five class III, five class IV, and five class V restorations completed on a manikin simulator to competency; and
 - c. At least 10 hours of making final impressions, placement of a non-epinephrine retraction cord, final cementation of crowns and bridges after preparation, and adjustment and fitting by the dentist, and no less than four crown impressions, two placements of retraction cord, five crown cementations, and two bridge cementations on a manikin simulator to competency.
 4. Clinical experience applying the techniques learned in the preclinical coursework and laboratory training in the following modules:
 - a. At least 30 hours of placing, packing, carving, and polishing of amalgam restorations, placement of a non-epinephrine retraction cord, and no less than six class I and six class II restorations completed on a live patient to competency;
 - b. At least 60 hours of placing and shaping composite resin restorations, placement of a non-epinephrine retraction cord, and no less than six class I, six class II, five class III, three class IV, and five class V restorations completed on a live patient to competency; and
 - c. At least 30 hours of making final impressions ; placement of non-epinephrine retraction cord; final cementation of crowns and bridges after preparation, adjustment, and fitting by the dentist; and no less than four crown impressions, two placements of retraction cord, five crown cementations, and two bridge cementations on a live patient to competency.
 5. Successful completion of the following competency examinations given by the accredited educational programs:
 - a. A written examination at the conclusion of didactic coursework; and
 - b. A clinical competency exam.
- C. An applicant may be registered as a dental assistant II with specified competencies set forth in subdivision a, b, or c of subdivisions B 3 and B 4 of this section.

- **18VAC60-30-140. Registration by endorsement as a dental assistant II.**

- A. An applicant for registration by endorsement as a dental assistant II shall provide evidence of the following:
 1. Hold current certification as a Certified Dental Assistant (CDA) conferred by the Dental Assisting National Board or another national credentialing organization recognized by the American Dental Association;
 2. Be currently authorized to perform expanded duties as a dental assistant in each jurisdiction of the United States;
 3. 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 the qualifications were not substantially equivalent the dental assistant can document experience in the restorative and prosthetic expanded duties set forth in **18VAC60-30-60** for at least 24 of the past 48 months preceding application for registration in Virginia.
- B. An applicant shall also:
 1. Be certified to be in good standing from each jurisdiction of the United States in which he is currently registered, certified, or credentialed or in which he has ever held a registration, certificate, or credential;
 2. Not have committed any act that would constitute a violation of § 54.1-2706 of the Code; and
 3. Attest to having read and understand and to remain current with the laws and the regulations governing dental practice in Virginia.

18VAC60-30-60. Delegation to dental assistants II.

Duties may only be delegated under the direction and direct supervision of a dentist to a dental assistant II who **has completed the coursework, corresponding module of laboratory training, corresponding module of clinical experience, and examinations specified in [18VAC60-30-120](#).**



Virginia Department of
Health Professions
Board of Dentistry

9960 Mayland Drive, Suite 300
Henrico, Virginia 23233
(804) 367-4538 (Tel)
(804) 698-4266 (eFax)
denbd@dhp.virginia.gov
www.dhp.virginia.gov/dentistry

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*	First	Middle/Maiden	Suffix
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Address of Record (Mailing Address)	City	State	Zip Code	Telephone Number
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Publicly Disclosable Address	City	State	Zip Code	Telephone Number
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Email Address:	Fax Number:
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Date of Birth ____/____/____ Month Day Year	Social Security Number or <u>Virginia</u> DMV Control Number on record** ____-____-____
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Graduation Date:	Dental Assisting Expanded Duties Program/School:	City/State:
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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 #
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Certification of Education/Form B	DANB Certification	Date Issued
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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 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:

Start Date & Completion Date	Name of School/Program (ADA-CODA)	Degree/Certificate Awarded
_____ to _____	_____	_____
_____ to _____	_____	_____
_____ to _____	_____	_____

B. Dental Assisting National Board Certification or other Dental Assistant Certification:

Certification Number	Date Issued	Expiration Date
_____	_____	_____

4. List all licenses/registrations/certificates, which you have been issued to practice as a dental assistant or as any other health care professional.

Jurisdiction	Number	Type	Date Issued	Exp. Date
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

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
"Any information concerning an arrest, charge, or conviction that has been sealed, including arrests, charges, or convictions for possession of marijuana, do not have to be disclosed."

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? [] Yes [] No

"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.

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? [] Yes [] No

"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.

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? [] Yes [] No

"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.

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.

**VIRGINIA BOARD OF DENTISTRY
APPLICATION AFFIDAVIT**

I hereby certify that I am the person referred to in the forgoing 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 assistants. 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



Virginia Department of
Health Professions
Board of Dentistry

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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 Program Coordinator of each School or Program which granted you a dental assisting degree or certificate.

APPLICANT _____ **GRADUATION DATE:** _____

DEAN/PROGRAM COORDINATOR: 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 (CODA) of the American Dental Association (ADA) **and** meets the Virginia Board of Dentistry educational programs requirements as stated in 18VAC60-30-116 of the regulations Governing the Practice of Dental Assistants. Please provide certification that the applicant named above successfully completed an expanded duties dental assisting program that includes didactic, laboratory and clinical 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.

SEAL

Signature

Print Name

Title

Date

DEAN/PROGRAM COORDINATOR: 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.



Virginia Department of
Health Professions
Board of Dentistry

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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 hereby 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 selected expanded didactic, laboratory and clinical duties on this form is true, complete, & correct:

NOTE: Duties may only be delegated under the direction and direct supervision of a dentist to a dental assistant II who has completed the coursework, corresponding module of laboratory training, corresponding module of clinical experience, and examinations specified in 18VAC60-30-120.:

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 _____.

SEAL/STAMP

Signature of Notary Public

Print Name



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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/registration. 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 Type & # _____ 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 on _____ 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: _____

SEAL

Signature

Title

Date

Print Name