For Board Use Only:

Permit #: ____________

DOP: _______________

Apply a current Photo here

ARKANSAS STATE BOARD OF DENTAL EXAMINERS
101 East Capitol Avenue, Suite 111
Little Rock, Arkansas 72201
Phone: 501.682.2085 Fax: 501.682.3543
Web: www.dentalboard.arkansas.gov Email: asbde@arkansas.gov

APPLICATION FOR REGISTRATION OF DENTAL ASSISTANTS

Please type. Handwritten applications will not be accepted. A copy of your current ***Healthcare Provider level CPR card*** must accompany this application. Failure to complete this form correctly will delay your permitting process.

Expanded Duties:

·Radiography ·Coronal Polishing ·Nitrous Oxide ·Sedation Monitoring

Application Fee: $75

Note: The Board office only accepts checks or money orders. Please make payable to "ASBDE".

Personal Information

Name: ____
First Name Middle Name Maiden Name Last Name

Mailing Address: ____
Address City State Zip

Social Security Number: ________-______-________ Date of Birth: ______________________

Sex: Male Female Race: ____________________ County: ________________________

Home Phone: ______________________________ Business Phone: __________________________

Email Address: ____
(Jurisprudence Exam will be emailed. Please put a valid email.)

How Are You Getting Registered?

Please check only one of the following:

	Graduate of a CODA-Accredited School	*Section A*
	On-the-job-training through an Arkansas-Licensed Dentist	*Section B*

*These are the *only ways* to obtain a permit in the State of Arkansas. You cannot be permitted through reciprocity.

SECTION A

Name of School: ____ Date Graduated: ____________

My certification is in:

☐ **Radiography** ☐ **Coronal Polishing**

Please attach a copy of your diploma from the school to the application.

SECTION B *(To be completed only by Arkansas-Licensed*

I have carefully observed and tested the above named dental assistant. In my judgment, the dental assistant is competent to perform the expanded duty(s) checked below under my personal supervision:

☐ **Radiography** ☐ **Coronal Polishing**

____

Dentist's Name (Print) AR License Number

__________________________________ _________________

Dentist's Signature Date

OPITIONAL

Nitrous Oxide: Please attach a copy of your nitrous oxide certificate from the Board-Approved instructor or ADA Accredited School.

Sedation Monitoring: Please attach a copy of your D.A.A.N.C.E. certificate from AAOMS. You must be registered in Nitrous Oxide in order to receive sedation monitoring as an expanded duty. (Note: This is the ***only*** course accepted for sedation monitoring).

In addition to the foregoing:

1. I hereby give my permission to the Arkansas State Board of Dental Examiners to secure information concerning me or any of the statements in this application from any person or any source the Board may desire.

2. I further agree to submit to questions concerning my qualifications as an applicant by the Board or any member thereof, and to substantiate if desired by the Board.

3. I have attached a check or money order to cover the application fee. I understand the fee is **non-refundable**. I further agree that if I do not return the Arkansas Jurisprudence Exam within *30 days* of it being emailed, my application and fee will be voided.

4. I agree to read the Dental Practice Act of Arkansas and the Rules & Regulations of the Board pertaining to Dentistry, Dental Hygiene and Dental Assisting; and I further state that all facts, statements, and answers contained in this application are true and correct; I am not omitting any information which might be of value to this Board in determining my qualifications, whether it is called for or not; and I agree that any falsification, omission or withholding of pertinent information or facts concerning my qualifications as an applicant shall be sufficient to bar me from licensure by the Arkansas State Board of Dental Examiners and such falsification, omission, or withholding shall serve as sufficient grounds for the revocation, cancellation, or suspension of my Arkansas Dental Assistant Permit if it is not discovered until after issuance.

____ ____________________

Signature of Dental Assistant Date