

APPLICATION FOR PRIOR APPROVAL OF EXPANDED FUNCTION TRAINING

Iowa Dental Board
400 SW 8th St., Suite D
Des Moines, IA 50309-4687
<http://www.dentalboard.iowa.gov>
515-281-5157

Note: A fee of \$10 is required to process your request. PLEASE TYPE OR PRINT.

Name of organization or person requesting approval: _____

Address: _____

Phone: _____ Fax: _____ Email: _____

Signature: _____ Date: _____

Expanded function course you are submitting for review:

- Taking Occlusal Registrations
- Placement and Removal of Gingival Retraction
- Taking Final Impressions
- Fabrication and Removal of Provisional Restorations
- Applying Cavity Liners and Bases, Desensitizing Agents and Bonding Systems
- Placement and Removal of Dry Socket Medication
- Placement of Periodontal Dressings
- Testing Pulp Vitality
- Monitoring Nitrous Oxide

Name of instructor providing training: _____

Educational background: (Attach a copy of curriculum vitae) _____

Course objectives: _____

1. Plan for initial assessment: _____

2. Resources used for didactic materials. Include a copy of the didactic materials for Board review.

3. Will lab training be provided? YES NO If yes, detail lab experience: _____

4. Describe your plan for the clinical component of training. Be specific. _____

5. Plan for post-course competency assessment: _____

6. Provide a detailed breakdown of the dates and times for the entire course: _____

7. Where do you intend to offer the course? _____

8. Who are the intended recipients of the course? _____

9. How many credit hours of continuing education are you requesting? _____

If available, please include a copy of the course brochure.
A copy of the didactic materials must also be included with your request.

You will be contacted after the Iowa Dental Board has reviewed your request.

MAIL COMPLETED APPLICATION, ALONG WITH A FEE OF \$10 FOR PRIOR APPROVAL OF CONTINUING EDUCATION HOURS, TO:

Iowa Dental Board
Expanded Function Committee
400 SW 8th St., Suite D
Des Moines, IA 50309-4687