Application for Qualification in Dental Radiography

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

- The application fee is non-refundable. ($40) Do not submit payment in cash.
- For specific requirements for a qualification in dental radiography, please refer to the Board’s rules at 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’.
- 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.
- Dental radiography qualifications 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 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.

Basis of Application
In order to qualify for a qualification in dental radiography in Iowa, you must complete the following:

- Have completed Board-approved training in dental radiography; and
- Have completed a Board-approved examination in dental radiography

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 qualification in dental radiography asks about any medical conditions you have that might impair your ability to practice. The Board also considers any prior criminal history and disciplinary actions when issuing qualifications in dental radiography. 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 issuance. We suggest you contact the Board office for information as to what documentation may be necessary as part of the application. Contacting the Board office about any of these situations may avoid unnecessary delays at the time of issuance.

Examination
You must successfully complete a Board-approved examination in the area of dental radiography. Iowa accepts the Dental Assisting National Board examination in dental radiography if completed after January 1986. You may complete the examination at a number of local community colleges. A list of testing sites is available at [http://www.dentalboard.iowa.gov/forms/docs/TestingSites.pdf](http://www.dentalboard.iowa.gov/forms/docs/TestingSites.pdf).

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

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 submit payment in cash.
## Application Checklist

- [ ] Application completely filled out; all questions answered.
- [ ] Application fee paid. ($40)

**Evidence of one of following:**
- [ ] On the job while under Dental Asst. Trainee status or registered dental assistant with an active registration status
- [ ] Graduate of a course of an accredited dental assisting program
- [ ] A nurse who holds an active Iowa license issued by the board of nursing

**Evidence of successful completion, within the previous two years, of a board-approved course of study in the area of dental radiography.** The course of study must include application of radiation to humans pursuant to Iowa Code section 136C.3.
- [ ] On the job while under trainee status using board approved curriculum
- [ ] At a board-approved postsecondary school
- [ ] From another program prior-approved by the board

**Affidavit of Applicant**

- [ ] Completed examination:
  - [ ] Dental radiography – state examination
  - [ ] Dental radiography – DANB

- [ ] Verification of training in dental radiography within the past 2 years.
- [ ] If a licensed nurse in Iowa, proof of current licensure with the Iowa Board of Nursing.
- [ ] If registered, certified or qualified as a dental assistant in another state – written verification from each state.
- [ ] Notarized copy of marriage certificate or divorce decree (if applicant’s name is different on documentation)

## Testing Sites


## Contact Us

If you have any questions, or need further assistance, please feel free to contact the Iowa Dental Board at (515) 281-5157 or [IDB@iowa.gov](mailto:IDB@iowa.gov).


# APPLICATION FOR IOWA 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.”**

<table>
<thead>
<tr>
<th>Full Legal Name: (Last, First, Middle)</th>
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<tr>
<th>Other Names Used: (e.g. Maiden Name)</th>
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<table>
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<tr>
<th>Home Address:</th>
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| City: |
| County: |
| State: |
| Zip: |

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<tr>
<th>Home Phone:</th>
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<tr>
<th>Home E-mail:</th>
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<table>
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<tr>
<th>Work Address:</th>
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| City: |
| County: |
| State: |
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<th>Work Phone:</th>
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<th>Work Fax:</th>
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<th>Work E-mail:</th>
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## TRAINING PROFILE

1. Are you a graduate of a Board-approved school of dental assisting? Year of graduation:  
   - Yes ☐  No ☐

2. Did you complete a formal course of study in dental radiography through a Board-approved program in the last two years or did you obtain clinical training in dental radiography while on trainee status during the last two years?  
   - If yes, attach proof of course completion or provide trainee number. Trainee #:  
   - Yes ☐  No ☐

3. Are you currently licensed by the Iowa Board of Nursing? License #: ________________  
   - Attach proof of current licensure.  
   - Yes ☐  No ☐

4. Have you completed a Board-approved examination in the area of Dental Radiography?  
   - Yes ☐  No ☐

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For office use only:  
Qualification #:  
Date Issued:
PERSONAL & CONFIDENTIAL DATA

Name of Applicant: ______________________________

PERSONAL & CONFIDENTIAL DATA

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.

Social Security Number: ______________________________
Gender: □ Male □ Female
U.S. 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: ______________________________

Date of birth: ______________________________
City of Birth: ______________________________
State of birth: ______________________________
Country of birth: ______________________________

EXAMINATION INFORMATION

1. Did you successfully complete the Board examination in dental radiography or the Dental Assisting National Board (DANB) radiography examination? (DANB radiography examination must have been completed after January 1986.)
   □ Yes □ No

2. Have you ever passed any of the Dental Assisting National Board (DANB) examinations?
   If yes, which examinations?
   ______________________________
   □ Yes □ No

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 (2) two years.

“Improper use of drugs or other chemical substances” means ALL 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, or use of any chemical substance prohibited by law.
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 14, 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).

<table>
<thead>
<tr>
<th></th>
<th>Yes □</th>
<th>No □</th>
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<tbody>
<tr>
<td>1.</td>
<td>Do you currently have a medical condition which in any way impairs or limits your ability to practice dental radiography with reasonable skill and safety?</td>
<td></td>
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<tr>
<td>2.</td>
<td>Are you currently engaged in the illegal or improper use of drugs or other chemical substances?</td>
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<tr>
<td>3.</td>
<td>Do you currently use alcohol, drugs, or other chemical substances that would in any way impair or limit your ability to practice dental radiography with reasonable skill and safety?</td>
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<td>4.</td>
<td>Are you receiving ongoing treatment or participation 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?</td>
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If you answered yes to any of the questions above, please provide a 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
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).**

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<thead>
<tr>
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<th>Question</th>
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<tbody>
<tr>
<td>Yes</td>
<td>No</td>
<td>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?</td>
</tr>
<tr>
<td>Yes</td>
<td>No</td>
<td>6. Have you ever been terminated or requested to withdraw from any dental assisting school or training program?</td>
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<tr>
<td>Yes</td>
<td>No</td>
<td>7. Have you ever received a warning, reprimand, or been placed on probation during a dental assisting training program or school?</td>
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<tr>
<td>Yes</td>
<td>No</td>
<td>8. Have you ever been denied a certificate/registration to practice dental radiography or dental assisting?</td>
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<tr>
<td>Yes</td>
<td>No</td>
<td>9. Have you ever voluntarily surrendered a certificate/registration issued to you by any professional licensing agency?</td>
</tr>
<tr>
<td>Yes</td>
<td>No</td>
<td>10. If yes, was disciplinary action pending against you, or were you under investigation by a licensing agency at the time the voluntary surrender of certificate/registration was tendered?</td>
</tr>
<tr>
<td>Yes</td>
<td>No</td>
<td>11. Have any judgments been entered against you resulting from your practice of dental radiography?</td>
</tr>
<tr>
<td>Yes</td>
<td>No</td>
<td>12. Are charges or an investigation currently pending relative to your dental radiography or dental assisting certificate/registration in any other state?</td>
</tr>
<tr>
<td>Yes</td>
<td>No</td>
<td>13. Has any jurisdiction of the United States or other nation ever limited, restricted, warned, censured, placed on probation, suspended, or revoked a certificate/registration you held?</td>
</tr>
<tr>
<td>Yes</td>
<td>No</td>
<td>14. Have you ever been notified of any charges filed against you by a licensing or disciplinary agency or any jurisdiction of the U.S. or other nation?</td>
</tr>
<tr>
<td>Yes</td>
<td>No</td>
<td>15. Do you understand that if a qualification 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 qualification?</td>
</tr>
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</table>
AFFIDAVIT OF APPLICANT

IN STATE OF __________________________ COUNTY OF __________________________

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 dental radiography qualification is issued to me, I understand that if I violate rules or regulations, my qualification 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 in this application, I hereby agree that such act shall constitute cause for denial, suspension, or revocation of my registration and/or radiography qualification.

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 radiography qualification 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: ________________
CERTIFICATION OF DENTAL RADIOGRAPHY TRAINING

The dental assistant’s supervising dentist, who provided training in dental radiography, should complete this form.

This certifies that _______________________________ was trained in dental radiography under my supervision* and the applicant has exhibited didactic knowledge and clinical proficiency in the area of dental radiography as indicated below.

Date: ________________________________  Location: ________________________________

_______________________________________________________________________________________
_______________________________________________________________________________________
_______________________________________________________________________________________

_______________________________________________________________________________________

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

*If the training was provided outside of Iowa, the training dentist must also complete the Dental Radiography Training Form to verify training in all competencies in the area of dental radiography as established by the Iowa Dental Board.