Print Form

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
DIVISION OF HEALTH LICENSURE AND REGULATION
OFFICE OF HEALTH RELATED BOARDS
665 MAINSTREAM DRIVE
NASHVILLE, TENNESSEE 37243

TENNESSEE BOARD OF DENTISTRY
(615) 532-5073 or 1-800-778-4123
http://tn.gov/health/topic/Dentistry-board

APPLICATION FOR REGISTRATION AS A DENTAL ASSISTANT

Application, practice, and renewal as a registered dental assistant is governed by T.C.A.§63-5-101, et. seq. And Rules 0460-01-.01, et. seq**.**

1. All **application fees are non-refundable**.
2. All documents and fees required to be submitted by you, or which must be requested from the appropriate institutions in the application process, must be mailed directly to:

Tennessee Board of Dentistry
665 Mainstream Drive
Nashville, TN 37243

3. Allow fourteen (14) working days for information mailed to our Office to be received and placed in your file. Federal Express or special courier services will not reduce the processing time. Additionally, if Federal Express or special courier services are used, you will be responsible for charges incurred.
4. If the application is not complete upon receipt by the Board's Administrative Office, a deficiency letter will be sent to you by certified mail. The supporting documentation requested in the letter must be received in the Board's Administrative Office sixty (60) days from the date of the initial deficiency letter. **Files not completed within sixty (60) days will be closed**. Please allow a minimum of 4 to 6 weeks for processing.
5. If you change your mailing address, you must notify the Board's Administrative Office, in **writing,** within thirty (30) days. Failure to abide by this law could affect your license, since failure to receive the renewal application does not relieve you of the responsibility for timely renewal.
6. **ANSWER ALL QUESTIONS ON THE APPLICATION. DO NOT LEAVE ANY AREA BLANK. RESPOND "NOT APPLICABLE" or "N/A" TO ALL QUESTIONS THAT DO NOT APPLY!**

You must write your social security number on the application for it to be complete. State law requires social security numbers on this application. TCA § 36-5-1301(a), as authorized by 42 U.S.C. § 405(c)(2)(C)(i). The number will be used to verify your identity and for any other purpose allowed by state or federal law.

CHECKLIST – use to complete your application.

NOTE: All submissions must be executed and dated less than one (1) year before receipt, or they will be rejected by the Board.

	Done
1. Tape to the first page of the Application a signed passport photograph of yourself (taken within the last twelve (12) months). You must sign the front of the photograph.	_____

2. Complete pages 1 through 6 of the Application. Sign page 6 of the Application then, mail all six pages to the Board's Office at the above address. _____

3. If you **are** or **have ever been** licensed, certified, registered, or permitted by any state to practice as a dental assistant (or as any other health care professional), you must request a verification from each and every state. The verification must be mailed directly to the Board's Office from the other state(s). _____

4. Submit two (2) **Original** letters of recommendation from licensed dental professionals who can attest to your good moral character. These letters must identify the individual(s) as licensed dental professionals, be submitted on letterhead, and bear the original signature of the author. _____

5. Copy the front and back of your current CPR card on a full-sized sheet of paper. The CPR certification must be a BLS Healthcare Provider course, or CPR/AED for the Professional Rescuer, or an equivalent course, which provides training for healthcare professionals in CPR and the use of an AED. The course must be conducted in person and include a skills examination on a manikin with a certified instructor. _____

6. Attach proof of U.S. or Canadian citizenship or evidence of being legally entitled to live in the U.S. (e.g. copy of birth certificate, voter's registration card, naturalization papers, or current visa status.) _____

7. Attach proof of having graduated from a high school (diploma) or successfully completing a general education development (G.E.D.) program (G.E.D. certificate). _____

8. **Paperclip a check or money order in the amount of $40.00 made payable to the "Board of Dentistry" to the front of the Application.** _____

9. **A criminal background check is required.** For instructions to obtain a criminal background check, go to http://tn.gov/health/article/CBC-instructions. _____

10. Please read the instructions on page 3 of the Application carefully. You must answer "Yes","No",or "N/A" to **every** question. **If any of your answers to the "competency questions" on page 3 of the Application were in the affirmative, please submit a separate document to explain the situation.** In addition to your explanation, the final documents or orders from the issuing states, courts and/or agencies must be submitted. _____

11. All applicants must complete, sign and have notarized the Declaration of Citizenship form and submit the documents required by the Declaration of Citizenship form. The Declaration is available online at http://tn.gov/assets/entities/health/attachments/PH-4183.pdf. _____

Additional certifications that you can submit an application to add to your registration:

- Dental Radiology Certification – see Rule 0460-04-.11
- Coronal Polishing Certification - see Rule 0460-04-.04
- Monitoring Nitrous Oxide Certification - see Rule 0460-04-.05
- Sealant Application Certification - see Rule 0460-04-.09
- Prosthetic Function Certification - see Rule 0460-04-.10
- Restorative Function Certification - see Rule 0460-04-.10

Proof of completion of the required education must be submitted and there is a fee for each certification. These procedures cannot be performed until the certification is added to your registration. Unless the certification course is offered as part of the ADA accredited dental assisting program or Board approved dental assisting program you attended, you must be registered as a dental assistant before attending the above certification courses. Please see the rule sections mentioned above for additional requirements and restrictions.

TAPE A CURRENT FULL-FACE PHOTOGRAPH HERE

(SIGNED BY APPLICANT ON THE FRONT OF THE PHOTO)

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
DIVISION OF HEALTH LICENSURE AND REGULATION
OFFICE OF HEALTH RELATED BOARDS
665 MAINSTREAM DRIVE
NASHVILLE, TENNESSEE 37243

TENNESSEE BOARD OF DENTISTRY
(615) 532-5073 or 1-800-778-4123
http://tn.gov/health/topic/Dentistry-board

FOR OFFICIAL USE ONLY

1222-001	**$ 30**
1222-006	**$ 10**
	$ 40

APPLICATION FOR REGISTRATION AS A DENTAL ASSISTANT

Please complete each question and return the application, supporting documents, and the Forty Dollar ($40) application fee to the above address.

PERSONAL INFORMATION

Name: _____
Last First Middle Maiden (if not used as your middle name)

Social Security Number: _____ U.S. Citizen: Yes ___ No___
All applicants must complete the Declaration of Citizenship form

Date of Birth: _____ Entitled to Live and Work in the U.S. Yes ___ No___

Mailing Address: _____

_____ Zip _____

Practice Address*: _____

_____

_____ Zip _____

E-mail address: _____

Do you wish to receive notifications, including renewal notification, from Department of Health via email? Please note, by opting in, all correspondence from the Department of Health will be delivered to the email address on file for you. You will no longer receive physical mail from our office. ___Yes ___ No

Race: _____ Phone: Home: _____

Gender: Female _____ Male _____ Office: _____

Are you a member of the U.S. armed forces who has, within the preceding 180 days, retired from the armed forces, received any discharge other than a dishonorable discharge from the armed forces, or been released from active duty to a reserve component of the armed forces? (If yes, please provide proof of status.) Yes ____ No _____

Are you the spouse of a member of the armed forces who has been transferred by the military to Tennessee or who has, within the preceding 180 days, retired from the armed forces, received a discharge other than a dishonorable discharge from the armed forces or been released from active duty to a reserve component? (If yes, please provide proof of same.) Yes ____ No _____

Have you ever been known by any other names besides what is listed above? Yes ____ No _____

If yes, please state in full every other name by which you have been known, the reason therefore, and inclusive dates so known: _____

_____

***If you have no practice address, notify the Board of your practice address within 30 days of obtaining a practice address. If you have multiple practice address, please attach an additional page listing all practice addresses.**

EMPLOYMENT INFORMATION

Please complete your entire employment history starting with the most current position first. Use the back of this page if you need additional space. If you have never worked in the Dental Assistant profession, list the other positions in which employed.

Company/ Employer:	**Supervisor:**	**Address:** (City, and State)	**Position:**	**Duties:**	**Dates** **From:** Mo./Yr.	**To:** Mo./Yr.
				____ exposure of radiographs ____ monitoring nitrous oxide ____ coronal polishing ____ place sealants ____ restorative (insert/pack/carve/finish permanent restorations) ____ final impressions for fixed & removable prosthetic appliances ____ other duties:______________________________		
				____ exposure of radiographs ____ monitoring nitrous oxide ____ coronal polishing ____ place sealants ____ restorative (insert/pack/carve/finish permanent restorations) ____ final impressions for fixed & removable prosthetic appliances ____ other duties:______________________________		
				____ exposure of radiographs ____ monitoring nitrous oxide ____ coronal polishing ____ place sealants ____ restorative (insert/pack/carve/finish permanent restorations) ____ final impressions for fixed & removable prosthetic appliances ____ other duties:______________________________		
				____ exposure of radiographs ____ monitoring nitrous oxide ____ coronal polishing ____ place sealants ____ restorative (insert/pack/carve/finish permanent restorations) ____ final impressions for fixed & removable prosthetic appliances ____ other duties:______________________________		
				____ exposure of radiographs ____ monitoring nitrous oxide ____ coronal polishing ____ place sealants ____ restorative (insert/pack/carve/finish permanent restorations) ____ final impressions for fixed & removable prosthetic appliances ____ other duties:______________________________		
				____ exposure of radiographs ____ monitoring nitrous oxide ____ coronal polishing ____ place sealants ____ restorative (insert/pack/carve/finish permanent restorations) ____ final impressions for fixed & removable prosthetic appliances ____ other duties:______________________________		
				____ exposure of radiographs ____ monitoring nitrous oxide ____ coronal polishing ____ place sealants ____ restorative (insert/pack/carve/finish permanent restorations) ____ final impressions for fixed & removable prosthetic appliances ____ other duties:______________________________		
				____ exposure of radiographs ____ monitoring nitrous oxide ____ coronal polishing ____ place sealants ____ restorative (insert/pack/carve/finish permanent restorations) ____ final impressions for fixed & removable prosthetic appliances ____ other duties:______________________________		

EDUCATIONAL INFORMATION

Please provide the following information for any dental assisting program, school or course you attended. Use the back of this page, if you need additional space.

From:	To:	Educational Institution	City, State	Major/ Studied	Year Graduated
Mo./Yr.	Mo./Yr.				
Mo./Yr.	Mo./Yr.				
Mo./Yr.	Mo./Yr.				

CERTIFICATION INFORMATION

	YES	NO
Are you or have you ever been licensed in this profession in another state?		
Are you or have you ever been licensed in any other profession in Tennessee or another state?		

List below **ALL STATES, COUNTRIES, OR PROVINCES IN WHICH YOU HAVE EVER BEEN OR ARE CURRENTLY LICENSED, PERMITTED, OR CERTIFIED**. Additional pages may be added if necessary. Request that verification of licensure be submitted directly to the Board's Office from each state.

STATE	PROFESSION	LICENSE NUMBER	CURRENT STATUS

The following questions must be answered	YES	NO
1. Are you certified by the Dental Assistant National Board (DANB)?		
2. Have you ever applied for registration as a dentist, dental hygienists or dental assistant in Tennessee?		

COMPETENCY INFORMATION

PLEASE ANSWER THE FOLLOWING QUESTIONS. If you answer "yes" to any of the questions in this part, you must supplement your affirmative response with a thorough explanation on a separate page. IN SUPPORT OF YOUR EXPLANATION, THE FINAL DOCUMENTS OR ORDERS FROM THE ISSUING STATES, COURTS, AND/OR AGENCIES MUST BE SUBMITTED ALONG WITH THIS APPLICATION. Additional information may be requested and/or required before a licensure decision may be made. For the purposes of these questions, the following phrases or words have the following meanings:

1. "**Ability to practice your profession**" is to be construed to include all of the following:

a. The cognitive capacity to make appropriate clinical diagnoses, exercise reasoned medical judgments, to learn, and keep abreast of medical developments;

b. The ability to communicate those judgments and medical information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and

c. The physical capability to perform professional tasks and procedures required of your profession, with or without the use of aids or devices, such as corrective lenses or hearing aids.

2. "**Medical Condition**" includes physiological, mental or psychological conditions including, but not limited to: orthopedic, visual, speech and/or hearing impairments, emotional or mental illness, specific learning disabilities, drug addiction, and alcoholism.

3. "**Minor Traffic Offense**" generally means moving and non-moving violations punishable by fines only and does not include offenses such as driving under the influence or while intoxicated or reckless driving.

4. "**Chemical substances**" is to be construed to include alcohol, 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.

5. "**Currently**" does not mean on the day of or even in the weeks or months preceding the completion of this application. Rather it means recently enough so that the use of drugs or alcohol may have an ongoing impact on one's functioning as a licensee or within the past two (2) years.

6. "**Illegal use of illicit or controlled substances**" means the use of substances obtained illegally (e.g., heroin or cocaine) as well as the use of controlled substances that are not obtained pursuant to a valid prescription or not taken in accordance with the directions of a licensed health care practitioner.

QUESTIONS: Please respond to ALL questions. If you answer "YES" to any question, please attach a written explanation.	**YES**	**NO**
1. Do you currently have any physical or psychological limitations or impairments caused by an existing medical condition which are reduced or ameliorated by ongoing treatment or monitoring, or the field of practice, the setting or the manner in which you have chosen to practice?	___	___
2. Do you currently use any chemical substances which in any way impair or limit your ability to practice your profession with reasonable skill and safety?	___	___

If so, please list: _____

[If you receive such ongoing treatment or participate in such a monitoring program, the Board will make an individual assessment of the nature, the severity, and the duration of the risks associated with an ongoing medical condition so as to determine whether an unrestricted license should be issued, whether conditions should be imposed, or whether you are not eligible for licensure.]

COMPETENCY INFORMATION
(continued)

QUESTIONS: Please respond to ALL questions. If you answer "YES" to any question, please attach a written explanation.	**YES**	**NO**
3. At any time within the past two years, have you engaged in the illegal use of illicit or controlled substances?	___	___
4. Are you currently participating in a supervised rehabilitation program or professional assistance program that monitors you to assure that you do not consume alcohol and/or do not engage in the illegal use of illicit or controlled substances?	___	___
5. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, voyeurism or other diagnosis of a predatory nature?	___	___
6. Have you ever held or applied for a license, privilege, registration or certificate to practice dentistry in any state, country, or province, that has been or was ever denied, reprimanded, suspended, restricted, revoked, otherwise disciplined, curtailed, or voluntarily surrendered under threat of investigation or disciplinary action?	___	___
7. Have you ever had staff privileges at any hospital or health care facility that were ever revoked, suspended, curtailed, restricted, limited, otherwise disciplined, or voluntarily surrendered under threat of restriction or disciplinary action?	___	___
8. Have you ever applied for or held a state or federal controlled substance certificate that was ever denied, revoked, suspended, restricted, voluntarily surrendered or otherwise disciplined or surrendered under threat of restriction or disciplinary action?	___	___
9. Have you ever been convicted (including a nolo contendere plea or guilty plea) of a felony or misdemeanor (other than a minor traffic offense) whether or not sentence was imposed or suspended?	___	___
10. Have you ever been rejected or censured by a professional association or society?	___	___
11. In relation to the performance of your professional services in any profession:		
a. Have you ever had a final judgment rendered against you;	___	___
b. Have you ever entered into any settlement of any legal action; or	___	___
c. Are there any legal actions pending against you or to which you are a party?	___	___
12. Have you ever held a license, registration, privilege or certificate in any profession that has ever been reprimanded, suspended, restricted, revoked, otherwise disciplined, curtailed, or voluntarily surrendered under threat of investigation or disciplinary action in any jurisdiction?	___	___
13. My name has been placed on the registry of persons who have abused, neglected or misappropriated the property of vulnerable individuals (Tennessee abuse registry or an abuse registry in another state)	___	___
14. Have you ever been dropped, suspended, expelled, or disciplined by any school or college for any cause?	___	___
15. Have you ever failed a dental examination? (National Boards, regional or state)	___	___
If yes, which exam and how many times have you failed? _____		

AFFIDAVIT AND RELEASE

I, _____, of _____,
(Applicant's Name) *(City)* *(State)*
being duly sworn and identified as the person referred to in this application attests to the truth of each statement made in said application. I further swear that I have read and understand the law and the Rules and Regulations regarding the practice of my profession, which are posted on the Board's Internet site and/or were provided to me by the Board office, and agree to abide by them in the practice as a dental assistant in the State of Tennessee.

I HEREBY:

SIGNIFY my willingness to appear to answer such questions as the Board may find necessary, which may include a full Board interview.

RELEASE to the Board, its staff, and their representatives, any and all documentation necessary now and in the future to establish my physical and mental capabilities to safely practice as a dental assistant.

AUTHORIZE the Board, its staff, and their representatives to consult with my prior and current associates and others who may have information bearing on my professional competence, character, health status, ethical qualifications, ability to work cooperatively with others, and other qualifications.

RELEASE from liability the Board, its staff, and all their representatives and any and all organizations which provide information for their acts performed and statements made in good faith and without malice concerning my competence, ethics, character, and/or other qualifications, for certification.

ACKNOWLEDGE that I, as an applicant for licensure, have the burden of producing adequate information for a proper evaluation of my professional, ethical, and other qualifications, and for resolving any doubts about such qualifications.

AUTHORIZE release, use and disclosure of otherwise HIPAA protected health information to the limited extent necessary for my application to receive full consideration up to and including discussion in a public forum should that become necessary.

THIS CERTIFIES THAT THE INFORMATION SUBMITTED BY ME IN THIS APPLICATION IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

_____ _____
SIGNATURE **DATE**