Oregon
Tina Kotek, Governor

Board of Dentistry
1500 SW 1st Ave, Ste 770
Portland, OR 97201-5837
(971) 673-3200
Fax: (971) 673-3202
www.oregon.gov/dentistry

MEETING NOTICE

DENTAL ASSISTANT WORKFORCE SHORTAGE ADVISORY COMMITTEE MEETING (DAWSAC)

Oregon Board of Dentistry

ZOOM MEETING INFORMATION (not an in person meeting)
https://us02web.zoom.us/j/82358253325?pwd=3D0PI1YH1bbYxorZOCBPJi61SmkyQC.1
Dial-In Phone #: 1-253-215-8782 ● Meeting ID: 823 5825 3325 ● Passcode: 217099

September 23, 2025
5 pm – 6:30 pm

Committee Members:
Co-Chair, Terrence Clark, DMD
Co-Chair, Ginny Jorgensen
Amberena Fairlee, DMD - ODA Rep.
Laura Vanderwerf, RDH - ODHA Rep.
Kari Hiatt - ODAA Rep.
Kimberly Perlot, RDH, DT – DT Rep
Lynn Murray
Carmen Mons
Cassie Gilbert
Megan Barron
Alexandria Case
Jessica Andrews
Alyssa Kobylinsky
Amanda Nash

AGENDA
Call to Order: Dr. Terrence Clark, Chair

- Public Meeting Notice
  - Governing bodies subject to Public Meetings Law – **Attachment #1**
- Review & Approve Minutes of May 13, 2025, DAWSAC Meeting
  - Meeting Minutes – **Attachment #2**
- OBD Letter to Governor – Board asking for discretion to hold DAWSAC Meetings as needed, not each quarter - **Attachment #3**
- Review HB 3223 and information regarding the formation of this Committee - **Attachment #4**

  The Statute has been updated incorporating HB 3223 into statute.
  ORS 679.330 Advisory committee on dental assistant workforce shortage. (1) The Oregon Board of Dentistry shall convene an advisory committee of at least seven members to study the dental assistant workforce shortage and to review the requirements for dental assistant certification in other states. The committee shall provide advice to the board on a quarterly basis on how to address the dental assistant workforce shortage in this state.
- Review and Discuss: South Dakota discussion of allowing dental assistants to administer nitrous oxide **- Attachment #5**
- Article - Law removes registration requirement for Iowa dental assistants - **Attachment #6**

This meeting is being held remotely via Zoom. A request for accommodations for persons with disabilities should be made at least 48 hours before the meeting to Haley Robinson at (971) 673-3200.

- Article - Universal dental assistant license - **Attachment #7**

- Radiologic Proposal from Amanda Nash & Alex Case - **Attachment #8**

- Article – Difference between Certified DA and Registered DA and neighbor states DA
  - **Attachment #9**
  - **Attachment #10**

- Ginny Jorgensen's submissions for this meeting.
  - OPA Opinion - **Attachment #11**
  - Adopting substandard… -**Attachment #12**
  - CDT Procedure… - **Attachment #13**
  - OBD Survey **- Attachment #14**

- ODAA Statement - **Attachment #15**

- ODHA DAWSAC Letter - **Attachment #16**

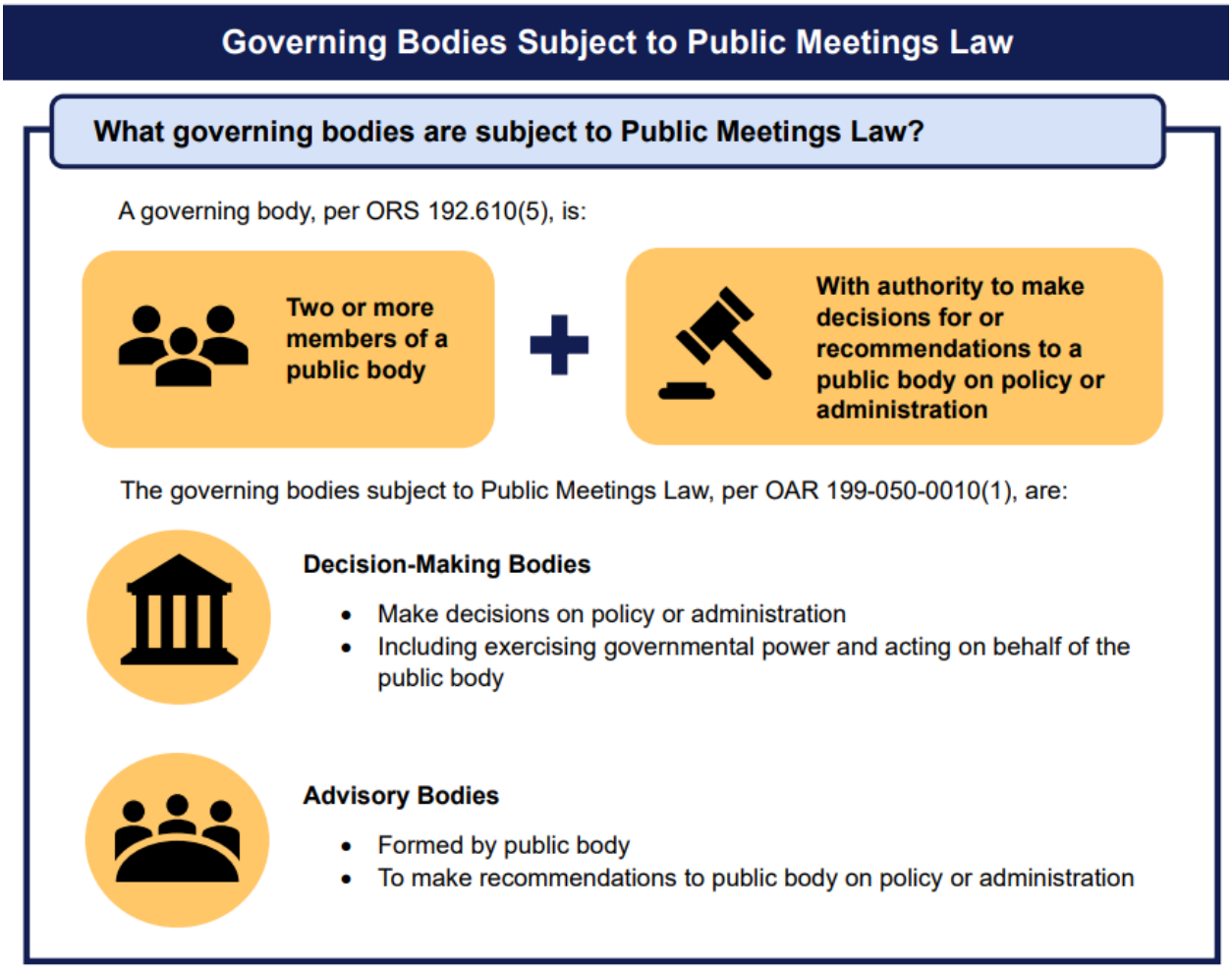
- DA Employment Trends - **Attachment #17**

Open Comment – this may be limited by the Chair and the meeting may end before 6:30 p.m. if all agenda topics have been covered by the committee.

The date for the next DAWSAC Meeting will be set by the Co-Chairs and shared with all as soon as it is finalized.

Adjourn

This Committee is subject to Public Meetings Law



DRAFT

OREGON BOARD OF DENTISTRY
DENTAL ASSISTANT WORKFORCE SHORTAGE ADVISORY COMMITTEE MEETING MINUTES (DAWSAC)
May 13, 2025

MEMBERS PRESENT: Terrence Clark, DMD, Co-Chair
Ginny Jorgensen, Co-Chair
Amberena Fairlee, DMD – ODA Rep.
Lisa Rowley, RDH – ODHA Rep.
Kari Hiatt – ODAA Rep.
Kari Ann Kuntzelman, DT – DT Rep.
Lynn Murray
Alexandria Case
Jessica Andrews
Alyssa Kobylinsky
Amanda Nash
Carmen Mons

STAFF PRESENT: Stephen Prisby, Executive Director
Kathleen McNeal, Licensing Manager
Dawn Dreasher, Office Specialist

ALSO PRESENT: Joanna Tucker-Davis, Senior Assistant Attorney General

VISITORS PRESENT: Jen Hawley Price, DANB; Mary Harrison, ODAA;
VIA TELECONFERENCE* Manu Chaudhry, D.D.S. Katherine Landsberg, DANB

*This list is not exhaustive, as it was not possible to verify all participants at the teleconference.

Call to Order: The meeting was called to order by Chair Ginny Jorgensen at 5:00 p.m. via Zoom.

Chair Jorgensen welcomed everyone to the meeting and had the DAWSAC Members, OBD staff and Assistant Attorney General introduce themselves.

Self-Introductions of Committee Members
Committee members introduced themselves and shared information about their current positions in the dental assisting field.

Approval of February 14, 2025 Minutes
Dr. Clark moved and Ms. Hiatt seconded that the Committee approve the minutes from the February 14, 2025 DAWSAC Committee Meeting as presented. The motion passed with TC, GJ, AF, LR, KH, LM, AC, JA, AK, AN and CM voting Aye.

DAWSAC Packet Introduced
A copy of the attached HB 3223 was reviewed, and information regarding the formation of this Committee was shared.

Attachment #2

There was approximately 20 minutes of general discussion amongst the members on dental assistant's work, and pros and cons of expanding duties of assistants. No action or motions were made. A recording of the meeting is available.

DANB Workgroup Draft Model

Chair Jorgensen introduced the DANB sponsored draft model. Ms. Katherine Landsberg presented an overview of the model, explaining that the stakeholder comment period has begun. The link to the draft model survey and other DANB information will be sent to the OBD, and the director and staff can make it available to anyone interested.

Open Comment

Dr. Manu Chaudhry, a member of the Oregon Healthcare Workforce Committee, clarified that he believes Oregon's dental workforce has reached a crisis level. Dr. Chaudhry added that he believes the dental assisting shortage is more about price and culture rather than the professional certification process. He stated his support for a formal compensation model.

Chair Jorgensen announced that 24 Expanded Function Dental Assistants had received their local anesthetic certificate.

ADJOURNMENT

The meeting was adjourned at 6:04 p.m. Chair Jorgensen stated that the next DAWSAC meeting will be scheduled at a later date and will be in approximately four months.

At the August 25, 2023 Board Meeting the Oregon Board of Dentistry (OBD) established a new standing Advisory Committee named the "Dental Assistant Workforce Shortage Advisory Committee (DAWSAC)" per ORS 679.280, to review, discuss and make recommendations to the Board on addressing workforce shortages in accordance with HB 3223 (2023).

The section of HB 3223 relevant to this is included for reference:

SECTION 5. (1) The Oregon Board of Dentistry shall convene an advisory committee of at least seven members to study the dental assistant workforce shortage and to review the requirements for dental assistant certification in other states. The committee shall provide advice to the board on a quarterly basis on how to address the dental assistant workforce shortage in this state.

(2)(a) In appointing members to the advisory committee, the board shall prioritize diversity of geographic representation, background, culture and experience.

(b) A majority of the members appointed to the committee must have experience working as dental assistants.

SECTION 6. This 2023 Act takes effect on the 91st day after the date on which the 2023 regular session of the Eighty-second Legislative Assembly adjourns sine die.

This advisory committee will meet no less than four times per calendar year once established, and generally be scheduled concurrently with regular OBD Board Meetings. The OBD President will designate two Co-Chairs of the Committee whom will be OBD Board Members. Preference will be given to Board Members who have past experience working as a dental assistant.

The advisory committee shall include five representatives from the Oregon dental assistant community who are currently or have worked as an Oregon dental assistant. The OBD President will select the members, and utilize the legislative criteria, if more than five people volunteer to serve on this advisory committee.

The advisory committee will also include one representative from each of the professional associations: The Oregon Dental Association, The Oregon Dental Hygienists' Association and the Oregon Dental Assistants Association and eventually one from the Oregon Dental Therapy Association (should that be established).

The Advisory Committee members will bring relevant topics and agenda items to the meetings, be meaningfully engaged on the relevant issues, offer solutions and assist in gathering speakers, data and information.

The inaugural DAWSAC meeting is tentatively scheduled for October 27, 2023.

Oregon
Tina Kotek, Governor

Board of Dentistry
1500 SW 1st Ave, Ste 770
Portland, OR 97201-5837
(971) 673-3200
Fax: (971) 673-3202
www.oregon.gov/dentistry

June 25, 2025

Via Email
The Honorable Governor Kotek
Office of the Governor

Dear Governor Kotek,

The Oregon Board of Dentistry (OBD) met on June 13, 2025, at its regular board meeting. The Board Members discussed a number of issues and directed me to send me this letter to you on two important matters.

1.) HB 3223 passed in 2023, directed the OBD to address the dental assistant work force shortage in Oregon by convening a new advisory committee to make recommendations to the OBD on a quarterly basis. HB 3223 is now enshrined in law under ORS 679.330.

The OBD stood up the new Dental Assistant Workforce Shortage Advisory Committee (DAWSAC) in 2023. It has held regular quarterly meetings since the inaugural meeting on October 27, 2023. The issue is that the legislation did not have any end or sunset date to the meetings of this workgroup. It is directed to meet quarterly in essence forever.

Possible Language Amendment:

ORS 679.330 Advisory committee on dental assistant workforce shortage. (1) The Oregon Board of Dentistry shall convene an advisory committee of at least seven members to study the dental assistant workforce shortage and to review the requirements for dental assistant certification in other states. The committee shall provide advice to the board on a quarterly basis **or as needed at the Board's discretion** on how to address the dental assistant workforce shortage in this state.

The OBD recommends that legislation be introduced and supported to allow the OBD to have this advisory committee meet as needed and at the discretion of the OBD.

2.) HB 2220 passed in 2019, allowed Oregon licensed dentists to prescribe and administer vaccines to a patient, provided rules and criteria were met. HB 2220 is now enshrined in law under ORS 679.552. This historic legislation among the first in the U.S., was timely as the OBD implemented rules effective January 1, 2020, allowing this ahead of the worldwide covid pandemic that year. During the pandemic, dental hygienists were allowed to administer covid vaccines and there were no Board complaints or any negative consequences that came to the OBD's attention in helping combat the pandemic.

The OBD recommends that legislation be introduced and supported to allow Oregon licensed dental hygienists the opportunity to administer vaccinations under the supervision of an Oregon licensed dentist. This concept has widespread support in the oral health education community and with professional associations. The OBD would proudly introduce a legislative concept on this change and/or support legislators and professional associations to do so.

Respectfully,
Stephen Prisby
OBD Executive Director

Outlook

AADA Member Request: Unregistered Dental Assistants/Nitrous Oxide

From Katherine Landsberg <klandsberg@danb.org>
Date Thu 7/10/2025 5:35 AM
To Brittany Novotny <brittany@sdboardofdentistry.com>

Dear AADA Members:
Please see the request below from Brittany Novotny of South Dakota. Please send your responses directly to Brittany. You can cc me if you wish.
Thank you!
Katherine

Greetings:

Our Board has received a petition from our Dental Association asking the Board to promulgate a rule that would allow unregistered Dental Assistants that are at least 18years of age to take a course and then obtain a permit to administer Nitrous Oxide to patients. Unregistered Dental Assistants include anyone hired off the street. There is no educational requirement for an unregistered Dental Assistant in South Dakota. Do any of your states authorize this? If they do, could you please send me a link to your regulations (brittany@sdboardofdentistry.com)? Any information you can provide is appreciated. Thanks!

Brittany

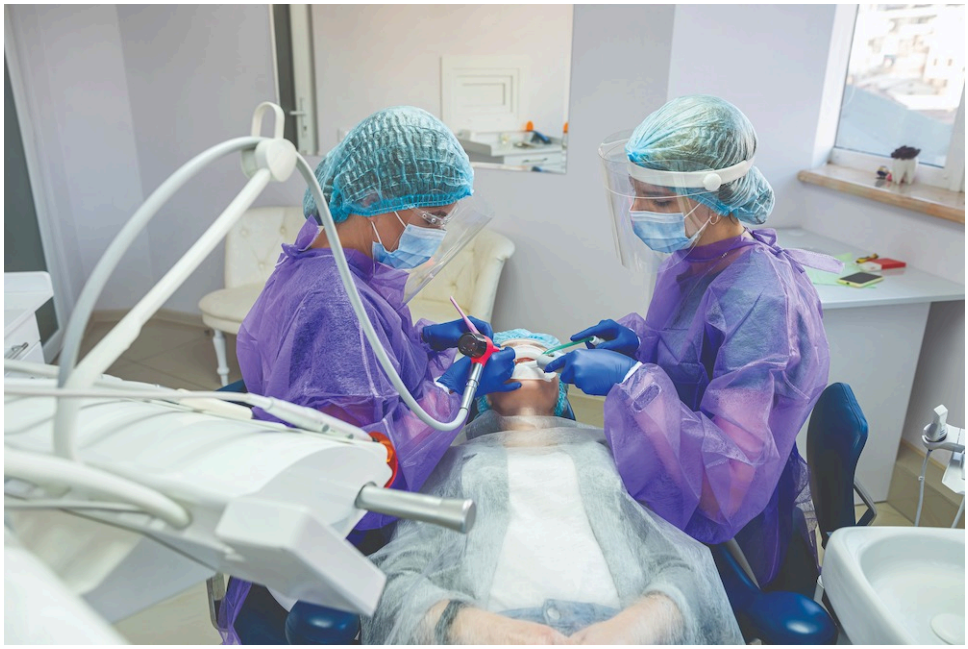
Brittany Novotny, JD, MBA
Executive Secretary
South Dakota State Board of Dentistry
PO Box 1079/1351 N. Harrison Ave.
Pierre, SD 57501
Ph: 605-224-1282
Fax: 888-425-3032
www.sdboardofdentistry.org

Law removes registration requirement for Iowa dental assistants

Change aims to give dental offices more flexibility in light of workforce issues

by **Mary Beth Versaci**

May 20, 2025



Dental assistants in Iowa will no longer need to register with the state dental board, thanks to a new law that removes the registration requirement for assistants to make it easier for dental offices to hire and train them.

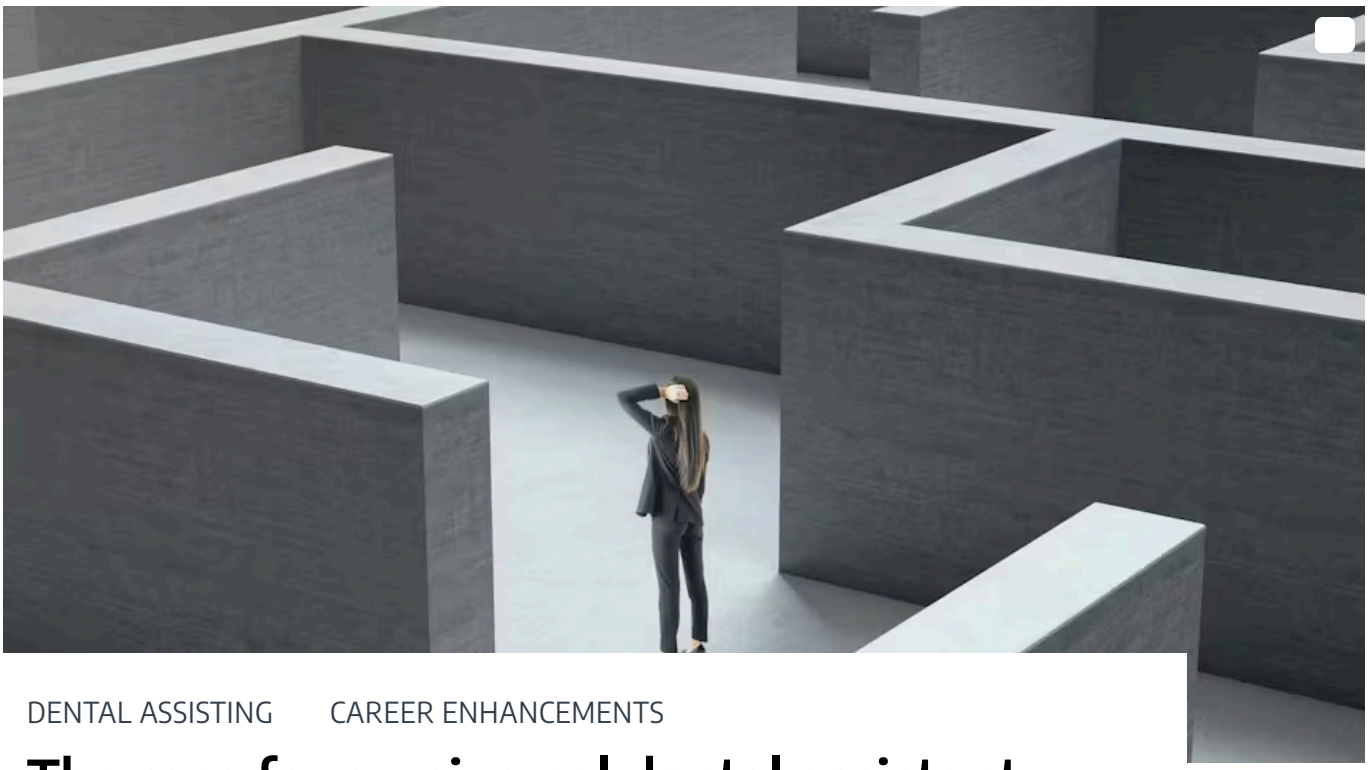
“The IDA is excited about the passage of HF 805,” said Christopher Bogue, D.D.S., immediate past president of the Iowa Dental Association and member of the American Dental Association’s Council on Dental Practice. “We have been dealing with workforce issues in Iowa, and it has been challenging for dental offices to hire dental assistants. HF 805 will provide dental offices in Iowa with greater flexibility to hire, train and retain the dental assistant staff they need.”

The Iowa Dental Association worked with two dentists in the Iowa Legislature — Rep. Steven Bradley, D.D.S., and Rep. Tom Jeneary, D.D.S. — to develop the bill, which was signed into law May 1. The registration change will take effect once new rules are developed by the Iowa Dental Board.

“All of Iowa’s neighboring states allow for some form of unregistered dental assistants to practice, leaving Iowa in a unique position of requiring additional burdens,” said Josh Carpenter, J.D., government affairs director for the Iowa Dental Association.

The law will allow unregistered dental assistants to work in a dental office with potentially the same scope of practice as registered dental assistants, depending on their training. Unregistered dental assistants may be able to perform expanded functions and participate in radiography, but the state dental board can require additional education and training for them, Mr. Carpenter said.

“Dentists will need to train unregistered dental assistants to ensure competency,” he said.



DENTAL ASSISTING CAREER ENHANCEMENTS

The case for a universal dental assistant license in the United States

Dental assistants are essential to safe, quality dental care—so why is their licensing a state-by-state maze? It's time for a universal, national standard in dental assisting.

Erin Hendricks, DA, CCHW

June 16, 2025

What you'll learn in this article:

- Why dental assistant licensing varies drastically across states.
- How inconsistent regulations undermine workforce mobility.
- The impact of nonstandardized training on patient safety.
- The economic and operational costs of redundant credentialing, both for dental assistants and employers.
- The case for a universal dental assistant license.

In a health-care system that strives for consistency, accessibility, and equity, there's a glaring omission in dental care policy—the lack of a universal dental assistant license. Despite playing a vital role in delivering safe, efficient, and compassionate dental care, dental assistants in the US operate under a fractured regulatory framework that varies significantly by state.

This inconsistency undermines professional mobility, complicates hiring for dental practices, and ultimately affects the quality of patient care. It's time to ask: Shouldn't dental assistants be held to a standardized national credential just like nurses or radiologic technologists?

Dental assisting: A profession without a passport

Licensing and certification requirements for dental assistants differ dramatically across the 50 states. Some states, such as Minnesota and Oregon, require formal certification and continuing education for advanced duties. Others, like Alabama or Hawaii, have minimal regulatory standards.

This disparity means a dental assistant trained and certified in one state may be ineligible to perform the same duties when moving to another state, not because of competency, but because of bureaucratic barriers.

According to the Dental Assisting National Board (DANB):[1]

- Only 38 states recognize or require certification for expanded functions dental assistants.
- 12 states have no requirement for formal credentialing, even for invasive or technical procedures.

- Over 400,000 dental assistants are currently employed in the US, many of whom are affected by this fragmented system.

What message does that send to professionals committed to their field, or to patients expecting standardized care?

Career Enhancements

Oral preventive assistants can be a good thing for dental...

Erin Hendricks, DA, CCHW

Career Enhancements

Universal framework for dental assistants moves one step closer

Meg Kaiser

Quality of care and patient safety: What's at stake?

Dental assistants aren't just "extra hands"—they're essential partners in clinical procedures, infection control, radiographic imaging, and patient communication. Inconsistent training standards can lead to variability in sterilization techniques and infection prevention, radiographic image quality and radiation safety, emergency response protocols, and chairside assistance during surgical procedures.

From a patient's perspective, a dental visit in Texas should offer the same level of safety and professionalism as one in Massachusetts. Right now, that's not guaranteed.

Dental assistant workforce mobility: A national need

The US Bureau of Labor Statistics projects 7% growth in dental assistant jobs from 2022 to 2032, faster than the national average. But growth means little if professionals are trapped by geography.[2]

Consider this: a certified dental assistant from Arizona relocates to Maryland to support a spouse's military transfer. Despite years of experience and continuing education, they may face delays in recredentialing, redundant coursework or exams, or temporary underemployment or job loss.

This isn't just inefficient; it's unjust. A universal license would facilitate interstate mobility, allowing skilled professionals to meet shifting health-care needs, especially in rural or underserved areas where staffing shortages are most acute.

Economic and operational efficiency within the dental profession

Redundant credentialing costs time and money, not only for assistants, but for dental practices, state boards, and educational institutions. According to DANB, assistants can spend upwards of $1,000 on state-specific exams, fees, and retraining, not including lost wages.[3]

For employers, inconsistent regulations mean hiring delays, onboarding challenges, and legal uncertainty about who is allowed to do what in the operatory. A universal license would reduce this administrative burden, streamline hiring practices, and foster a more flexible, responsive dental workforce.

A national standard for DAs is within reach

What's the solution? It's a nationally recognized, portable dental assistant license, based on a core set of standards for education, ethics, safety, and clinical competence. This could be administered through an expanded role for the ADAA or under the umbrella of a national accrediting body similar to the National Council of State Boards of Nursing (NCSBN).

Benefits would include a clear career path for students entering the field, enhanced credibility and respect for dental assistants, a stronger, more unified dental workforce, and improved consistency in patient care across the country.

We must ask: why do we hold different standards for dental assistants based solely on state lines? How can we expect excellence in care when the professional standards behind that care vary so widely? What could a unified system mean for the future of dental health access in America?

Dental assistants are more than support staff—they're trained professionals who deserve recognition, mobility, and respect. A universal dental assistant license isn't

just a policy proposal; it's a commitment to equity, safety, and progress in oral health care.

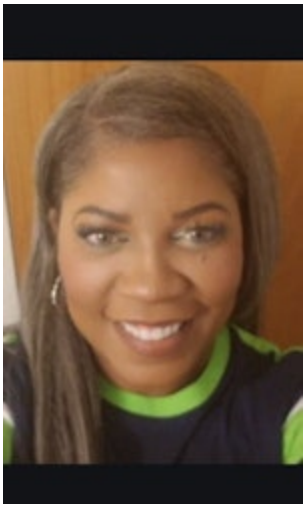
Let's hope the dental profession can soon move toward a system that supports the professionals behind the smiles, no matter where they practice.

References

1. 1. DANB exam content validation study summary reports. Dental Assisting National Board Inc. August 2, 2921. Accessed June 16, 2025. https://danbsfprodassets.azureedge.net/assets/docs/default-source/content-validation-study-reports/danb-exam-content-validation-study-2021-summary-reports.pdf?sfvrsn=2fd5d416_3

2. 2. Occupational Outlook Handbook. Dental Assistants. US Bureau of Labor and Statistics. Last modified April 18, 2025. Accessed June 15, 2025. https://www.bls.gov/ooh/healthcare/dental-assistants.htm

3. 3. State dental assisting requirements. Dental Assisting National Board Inc. Accessed June 16, 2025. https://www.danb.org/state-requirements



About the Author

Erin Hendricks, DA, CCHW

Erin Hendricks, DA, CCHW, spent 35 years as a dental assistant in the District of Columbia, Maryland, Virginia area, starting her journey with the US Air Force; she says nothing says "precision" like military training. As the president-elect of the ADAA and a guest speaker at Yankee Dental Congress 2024 and SmileCon 2025, Erin is able to share her passion for the dental assisting profession. When she's not advocating for dental assistants, she's either perfecting a smokey eye (makeup is her side gig) or reposting hilarious memes on social media.

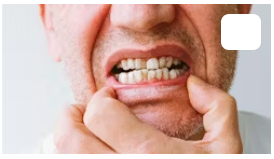
Attachment #7

Pamela Maragliano, DMD

Research and News

Are fluoride bans going to escalate the country's dental health crisis?

Sarah Butkovic, MA, BA



Oral-systemic Health

Bridging the dental and naturopathic practices: A holistic approach to oral health

Laurence V. Hicks, DC, ND, DO

Cosmetic and Whitening

The dangers of snap-on veneers: another TikTok oral trend

Sarah Butkovic, MA, BA

LOAD MORE CONTENT

Dental Radiology Certification

Removing Barriers

Presented by Amanda Nash and Alex Case

Disclosure: These are our individual opinions and not those of the organizations we work for.

Attachment #8

Pathway I

For a dental assistant to obtain an Oregon Radiologic Proficiency Certificate they need to do the following:

- First, complete a course of instruction in radiography that is provided by an Oregon Board of Dentistry approved school or course provider.
- Second, pass the DANB Radiation Health and Safety (RHS) exam or another board-approved exam.
- Third, obtain a signature from an Oregon licensed dentist or dental hygienist verifying that they are proficient in taking radiographs, within six months of first being authorized to take them.
- Finally, apply to DANB for the Oregon Radiologic Proficiency Certificate.

Eligibility Pathways for Radiologic Proficiency Certificate in Oregon

Performance of radiography procedures by dental assistants is regulated by the Oregon Board of Dentistry (OBD) and requires that dental assistants earn a certificate in radiologic proficiency. The Dental Assisting National Board, Inc. (DANB), on behalf of the OBD, administers the Radiologic Proficiency Certificate program, a service that includes providing information regarding exams and certificates, distributing materials, administering the required exam, and issuing certificates.

A dental assistant must meet the following requirements to earn an Oregon Radiologic Proficiency Certificate:

Pathway I

1. Complete an Oregon Board of Dentistry-approved course of instruction in radiography
   Acceptable documentation includes:
   - Copy of transcript, diploma, radiology course completion certificate OR
   - Signed and dated letter (on letterhead) from the approved school/course provider verifying completion of the radiology course

AND

2. Pass the DANB Radiation Health and Safety (RHS®) exam or other board-approved exam
   Note: Documentation of passing the RHS exam is already on file with DANB and does not need to be submitted.

AND THEN

3. Obtain verification from an Oregon licensed dentist or dental hygienist that the dental assistant is proficient to take radiographs within six months of first being authorized to take radiographs

AND THEN

4. Apply to DANB for the Oregon Radiologic Proficiency Certificate.

Pathway II

1. Be certified in radiography in another state that has training and certification requirements substantially similar to Oregon's requirements
   OR
   Obtain verification from a licensed dentist of having been employed for at least 1,000 hours (outside the state of Oregon) in the past two years as a dental assistant taking radiographs

AND THEN

2. Apply to DANB for the Oregon Radiologic Proficiency Certificate.

.

IMPORTANT: Candidates must receive an ORCR certificate **<u>within six months</u>** of passing required exams.

*Upon completion of both an Oregon Board-approved radiography course and passing an approved exam (whichever is more recent), **a dental assistant is authorized to perform radiographic procedures for six months under the indirect supervision of a dentist, dental hygienist or dental assistant who holds an Oregon Radiologic Proficiency (ORCR) Certificate**. The authorized dental assistant must submit the ORCR certificate application and included proficiency verification form to DANB within that 6-month period or they are no longer able to perform radiographs until they earn the ORCR certificate.

If a dental assistant goes beyond the 6-month authorization period without earning their ORCR certificate, they will ONLY be able to perform radiographic procedures under DIRECT supervision of a licensed dentist or dental hygienist until they submit the ORCR certificate application and included radiologic proficiency verification form to DANB and earn the ORCR certificate.

<u>Direct Supervision:</u> A dentist must diagnose the condition to be treated, authorize the procedure to be performed, and remain in the dental treatment room while the procedures are performed.

<u>Indirect Supervision:</u> A dentist must authorize the procedures and be on the premises while the procedures are being performed. Unless otherwise specified, dental assistants work under indirect supervision in the dental office.

Inquiries regarding DANB exams, eligibility requirements and certificates should be addressed to DANB.

Inquiries regarding the state dental practice act should be addressed to:
Oregon Board of Dentistry, 1500 SW 1st Ave., Ste. #770, Portland, OR 97201,
or call 1-971-673-3200

Instructor License

In the state of Oregon, a dental assistant can obtain a license to teach courses in radiologic proficiency if they meet the following requirements:

- They have held an Oregon Certificate of Radiologic Proficiency for a minimum of 2 years.
- They verify continuous employment for the past 2 years as a chairside assistant or in an educational setting where taking radiographs is a primary function.
- Verification of passing the Radiation Health and Safety exam (RHS).

CERTIFICATE OF INSTRUCTOR APPROVAL

The OREGON BOARD OF DENTISTRY certifies that:

[redacted]
LICENSE NUMBER

Amanda Nash

has met the requirements
to teach courses in
Radiologic Proficiency.

Issued: 07/26/2022
Expires: 07/26/2026

Attachment #8

Board Approved Instructors

- Currently there are a total of 189 individuals who are licensed through the Oregon Board of Dentistry to teach courses in radiologic proficiency.
  - 81 are Oregon licensed dentists (DDS or DMD)
  - 30 are Oregon Registered Dental Hygienists (RDH)
  - 78 indicate no credentials (assumed dental assistants or dental therapists)
- Approximately 40% of the people who are licensed to teach courses in radiologic proficiency are not authorized to sign off that a dental assistant is proficient in taking radiographs.

A Barrier for Dental Radiology Certification

- A dental assistant with the proper credentials can obtain a license to teach courses in radiologic proficiency.
- A dental assistant who has completed the first two steps for obtaining their radiology certification is allowed to take radiographs under the indirect supervision of a dental assistant who holds an Oregon Radiologic Proficiency Certificate.
- Only an Oregon licensed dentist or dental hygienist is authorized to sign off that a dental assistant is proficient in taking radiographs.

2025 Radiologic Proficiency Verification Form

This form will be accepted through Dec. 31, 2025.

Must be filled out completely by dentist or dental hygienist licensed in the state of Oregon.

A dentist or dental hygienist may authorize a dental assistant who has completed the course and written exam requirements to perform radiographic procedures under the indirect supervision of a dentist, dental hygienist or dental assistant who holds an Oregon Radiologic Proficiency Certificate. The applicant for the Oregon Clinical Radiologic Proficiency Certificate must submit this form within six months of first being authorized by a licensed dentist or dental hygienist to expose radiographs.

Section A: Dentist of Dental Hygienist's Information

Licensed Dentist's or Hygienist's Name _____ Email (required) _____

License Number _____ Phone number _____

Dental Practice Address _____

City _____ State _____ Zip _____

Section B: Work Experience

A licensed dentist or dental hygienist, licensed in the state of Oregon (license will be verified by DANB staff), can assess the proficiency of a dental assistant to take radiographs in the state of Oregon.

Candidate's Name _____

By signing this form, I attest that the above-named candidate is proficient in taking radiographs.

Dentist/Dental Hygienist's Signature _____ Date _____

DANB • 444 N. Michigan Ave., Suite 900 • Chicago, IL 60611
Questions? 800-367-3262 or danbmail@danb.org

Email application to: financefax@danb.org
Do not submit twice or you will be charged twice.

administered pursuant to OAR 818-026-0050(5)(a), OAR 818-026-0060(12), OAR 818-026-0065(12), OAR 818-026-0070(12) and as provided in OAR 818-042-0070, OAR 818-042-0090 and OAR 818-042-0115.

(7) Prescribe any drug.

(8) Place periodontal packs.

(9) Start nitrous oxide.

(10) Remove stains or deposits except as provided in OAR 818-042-0070.

(11) Use ultrasonic equipment intra-orally except as provided in OAR 818-042-0100.

(12) Use a high-speed handpiece or any device that is operated by a high-speed handpiece intra-orally except as provided in OAR 818-042-0095, and only for the purpose of adjusting occlusion, contouring, and polishing restorations on the tooth or teeth that are being restored.

(13) Use lasers, except laser-curing lights.

(14) Use air abrasion or air polishing.

(15) Remove teeth or parts of tooth structure.

(16) Cement or bond any fixed prosthesis or orthodontic appliance including bands, brackets, retainers, tooth moving devices, or orthopedic appliances except as provided in OAR 818-042-0100.

(17) Condense and carve permanent restorative material except as provided in OAR 818-042-0095.

(18) Place any type of retraction material subgingivally except as provided in OAR 818-042-0090.

(19) Apply denture relines except as provided in OAR 818-042-0090(2).

(20) Expose radiographs without holding a current Certificate of Radiologic Proficiency issued by the Board (OAR 818-042-0050 and OAR 818-042-0060) except while taking a course of instruction approved by the Oregon Health Authority, Oregon Public Health Division, Office of Environmental Public Health, Radiation Protection Services, or the Oregon Board of Dentistry.

(21) Use the behavior management techniques known as Hand Over Mouth (HOM) or Hand Over Mouth Airway Restriction (HOMAR) on any patient.

(22) Perform periodontal assessment.

(23) Place or remove healing caps or healing abutments, except under direct supervision.

(24) Place implant impression copings, except under direct supervision.

(25) Any act in violation of Board statute or rules.

Stat. Auth.: ORS 679 & 680
Stats. Implemented: ORS 679.020, 679.025 & 679.250
Hist.: OBD 9-1999, f. 8-10-99, cert. ef. 1-1-00; OBD 22000(Temp), f. 5-22-00, cert. ef. 5-22-00 thru 11-18-00; OBD 1-2001, f. & cert. ef. 1-08-01; OBD 15-2001; f. 12-7-01, cert. ef. 1-1-02; OBD 3-2005, f. 10-26-05, cert. ef. 11-1-05; OBD 3-2007, f. & cert. ef. 11-30-07; OBD 1-2010, f. 6-22-10, cert. ef. 7-1-10; OBD 4-2011, f. & cert. ef. 11-15-11; OBD 2-2012, f. 6-14-12, cert. ef. 7-1-12; OBD 6-2014, f.7-2-2014, cert. ef. 8-1-2014; OBD 6-2015, f. 7-9-05, cert. ef. 10-1-15; OBD 2-2018, f. 10/04/18, ef. 1/1/19, OBD 2-2019, f. 10/29/2019, cert. ef. 1/1/2020, amend filed 11/08/2021, effective 01/01/2022

818-042-0050
Taking of X-Rays – Exposing of Radiographic Images

(1) A Licensee may authorize the following persons to place films/sensors, adjust equipment preparatory to exposing films/sensors, and expose the films and create the images under general supervision:

(a) A dental assistant certified by the Board in radiologic proficiency; or

(b) A radiologic technologist licensed by the Oregon Board of Medical Imaging and certified by the Oregon Board of Dentistry (OBD) who has completed ten (10) clock hours in a Board approved dental radiology course.

(2) A licensee may authorize a dental assistant who has completed a course of instruction approved by the Oregon Board of Dentistry, and who has passed the written Dental Radiation Health and Safety Examination administered by the Dental Assisting National Board, or comparable exam administered by any other testing entity authorized by the Board, or other comparable requirements approved by the Oregon Board of Dentistry to place films/sensors, adjust equipment preparatory to exposing films/sensors, and expose the films and create the images under the indirect supervision of a dentist, dental therapist, dental hygienist, or dental assistant who holds an Oregon Radiologic Proficiency Certificate. The dental assistant must submit within six months, certification by an Oregon licensed dentist, dental therapist or dental hygienist that the assistant is proficient to take radiographic images.

(3) A dental therapist may not order a computerized tomography scan.

Stat. Auth.: ORS 679
Stats. Implemented: ORS 679.025(2)(j) & 679.250(7)
Hist.: OBD 9-1999, f. 8-10-99, cert. ef. 1-1-00; OBD 2-2003, f. 7-14-03 cert. ef. 7-18-03; OBD 4-2004, f. 11-23-04 cert. ef. 12-1-04; OBD 4-2011, f. & cert. ef. 11-15-11; OBD 6-2014, f. 7-2-2014, cert. ef. 8-1-2014; OBD 6-2015, f. 7-9-15, cert. ef. 10-01-15; OBD 2-2016, f. 11-2-16, cert. ef. 3-1-17; OBD 2-2018, f. 10/04/18, ef. 1/1/19, OBD 2-2019, f. 10/29/2019, cert. ef. 1/1/2020, OBD 1-2022, amend filed 06/21/2022, effective 07/01/2022

818-042-0060
Certification – Radiologic Proficiency

(1) The Board may certify a dental assistant in

radiologic proficiency by credential in accordance with OAR 818-042-0120, or if the assistant:

(2) Submits an application on a form approved by the Board, pays the application fee and:

(a) Completes a course of instruction approved by the Oregon Board of Dentistry, in accordance with OAR 333-106- 0055 or submits evidence that the Oregon Health Authority, Center for Health Protection, Radiation Protection Services recognizes that the equivalent training has been successfully completed;

(b) Passes the written Dental Radiation Health and Safety Examination administered by the Dental Assisting National Board, Inc. (DANB), or comparable exam administered by any other testing entity authorized by the Board, or other comparable requirements approved by the Oregon Board of Dentistry; and

(c) Certification by an Oregon licensee that the assistant is proficient to take radiographs.

Stat. Auth.: ORS 679
Stats. Implemented: ORS 679.020, 679.025, 679.250
Hist.: OBD 9-1999, f. 8-10-99, cert. ef. 1-1-00; OBD 2-2003, f. 7-14-03 cert. ef. 7-18-03; OBD 4-2004, f. 11-23-04 cert. ef 12-1-04; OBD 3-2005, f. 10-26-05, cert. ef. 11-1-05; OBD 32007, f. & cert. ef. 11-30-07; OBD 4-2011, f. & cert. ef. 1115-11; OBD 3-2013, f. 10-24-13, cert. ef. 1-1-14; OBD 62014, f. 7-2-14, cert. ef. 8-1-2014; OBD 2-2018, f. 10/04/18, ef. 1/1/19, OBD 1-2022, amend filed 06/21/2022, effective 07/01/2022

818-042-0070
Expanded Function Dental Assistants (EFDA)

The following duties are considered Expanded Function Duties and may be performed only after the dental assistant complies with the requirements of 818-042-0080:

(1) Polish the coronal surfaces of teeth with a brush or rubber cup as part of oral prophylaxis to remove stains providing the patient is checked by a dentist or dental hygienist after the procedure is performed, prior to discharge;

(2) Remove temporary crowns for final cementation and clean teeth for final cementation;

(3) Preliminarily fit crowns to check contacts or to adjust occlusion outside the mouth;

(4) Place temporary restorative material in teeth providing that the patient is checked by a dentist before and after the procedure is performed;

(5) Place and remove matrix retainers for any type of direct restorations;

(6) Polish amalgam or composite surfaces with a slow speed hand piece;

(7) Remove excess supragingival cement from crowns, bridges, bands or brackets with hand instruments providing that the patient is checked by a dentist after the procedure is performed;

(8) Fabricate temporary crowns, and fixed partial dentures (bridges) and temporarily cement the temporary crown or fixed partial dentures (bridges). The cemented crown or fixed partial dentures (bridge) must be examined and approved by the dentist prior to the patient being released;

(9) Under general supervision, when the dentist is not available and the patient is in discomfort, an EFDA may recement a temporary crown or recement a permanent crown with temporary cement for a patient of record providing that the patient is rescheduled for follow-up care by a licensed dentist as soon as is reasonably appropriate.

Stat. Auth.: ORS 679 & 680
Stats. Implemented: ORS 679.020, 679.025 & 679.250
Hist.: OBD 9-1999, f. 8-10-99, cert. ef. 1-1-00; OBD 1-2004, f. 5-27-04, cert. ef. 6-1-04; OBD 3-2005, f. 10-26-05, cert. ef. 11-1-05; OBD 2-2009, f. 10-21-09, cert. ef. 11-1-09; OBD 62015, f. 7-9-15, cert. ef. 10-01-15; OBD 2-2016, f. 11-2-16, cert. ef. 3-1-17, OBD 2-2019, f. 10/29/2019, cert. ef. 1/1/2020

818-042-0080
Certification — Expanded Function Dental Assistant (EFDA)

The Board may certify a dental assistant as an expanded function assistant:

(1) By credential in accordance with OAR 818-042-0120, or

(2) If the assistant submits a completed application, pays the fee and provides evidence of;

(a) Certification of Radiologic Proficiency (OAR 818-042-0060); and satisfactory completion of a course of instruction in a program accredited by the Commission on Dental Accreditation of the American Dental Association; or

(b) Certification of Radiologic Proficiency (OAR 818-042-0060); and passage of the Oregon Basic, Infection Control or Certified Dental Assisting (CDA) examination, and the Expanded Function Dental Assistant examination, or equivalent successor examinations, administered by the Dental Assisting National Board, Inc. (DANB), or any other testing entity authorized by the Board; and certification by a licensed dentist that the applicant has successfully polished six (6) amalgam or composite surfaces, removed supra-gingival excess cement from four (4) crowns and/or fixed partial dentures (bridges) with hand instruments; placed temporary restorative material in three (3) teeth; preliminarily fitted four (4) crowns to check contacts or to adjust occlusion outside the mouth; removed four (4) temporary crowns for final cementation and cleaned teeth for final cementation; fabricated four (4) temporary crowns

Removing Barriers

- To enhance flexibility and efficiency in the administration of courses in radiologic proficiency, we propose expanding the list of individuals authorized to sign off on proficiency. Currently, only an Oregon licensed dentist or dental hygienist may sign off. We recommend including a dental assistant who is formally approved to teach the course as an additional authorized signatory.
- This adjustment does not remove dentists or dental hygienists from the process but rather provides an additional, qualified option. A dental assistant would be eligible to sign off only if they are licensed as an instructor by the Oregon Board of Dentistry.

Benefits of this proposal:

- Increased flexibility in course administration, especially in programs where dental assistants are the primary instructors.
- Recognition of the instructional role dental assistants already fulfill in delivering RHS training.
- Improved efficiency in completing administrative tasks, especially during high-volume periods or when dental providers are unavailable.
- Continued oversight and quality assurance, as all signatories: dentists, hygienists, or approved dental assistants, must meet instructional standards.
- This change supports the continued integrity of RHS education while promoting access and responsiveness within dental assisting programs.

Practice

What's the Difference Between a Certified Dental Assistant and a Registered Dental Assistant?

If you're thinking about becoming a dental assistant, you might be confused by the education and training requirements—and that's okay, because it can be confusing! Every state has different regulations regarding what you're allowed to do as an assistant, how long you have to go to school before becoming certified, and even whether you need to be certified at all. On top of that, dental assistant titles vary from state to state, with a hodgepodge of acronyms including things like RDA, CDA, EFRDA, CPFDA, and CDPMA—which can all have different certifying requirements and allowed duties depending on where you live.

The two most common titles you'll see are Registered Dental Assistant (RDA) and Certified Dental Assistant (CDA). While many states allow dental assistants to work with little to no training under the direct supervision of a licensed dentist, dental assistants who have earned the title of RDA or CDA have more freedom to work independently. They have proven advanced knowledge in the field, and are paid better for their skills than unlicensed assistants.

Certified Dental Assistants and Registered Dental Assistants are often similar in their training requirements and allowed duties. The difference is that Certified Dental Assistants are qualified through the Dental Assisting National Board and their certifications are valid in many states. Registered Dental Assistants are qualified by their respective individual states, many of which require CDAs to obtain additional training before they can become RDAs.

Beyond the RDA and CDA

Additional certifications and training are available beyond RDA and CDA. Many states offer extended function certifications in areas such as coronal polishing. Radiography is sometimes part of standard

training and sometimes requires extra certification. Other options include certifications in anesthesia, oral surgery, or orthodontics.

Get ready for alphabet soup

The table below gives a brief overview of the titles available and the training required for dental assistants in each of the fifty states of the U.S. These listings are not authoritative; they're just a general introduction. You can click the link at each state to get more detail from the appropriate dental board. Also, there are a couple things you'll see over and over in the list that we should define up front:

DANB — Dental Assisting National Board. The DANB offers a number of national certifications, including the CDA. Some states require that you pass DANB's CDA exam, while other states have their own exams that you must pass instead to become an RDA.

CODA — Commission on Dental Accreditation. CODA offers accreditation for many dental assisting schools, and many states require assistants to be graduates of one of these schools. If your state requires graduation from a CODA-accredited school, you can start your search for one here.

What are the requirements for being a dental assistant in my state?

State	Recognized Levels of Dental Assistant	
Alabama	Dental Assistant	No specific requirements to work under direct supervision of a licensed dentist
Alaska	Dental Assistant	No specific requirements to work under direct supervision of a licensed dentist
	Dental Assistant Qualified in Restorative Functions	Certification in restorative functions required
	Dental Assistant Qualified in Coronal Polishing Procedures	Certification in coronal polishing required
Arizona	Dental Assistant	No specific requirements to work under direct supervision of a licensed dentist
	Dental Assistant Qualified in Coronal Polishing Procedures	Must hold Arizona Coronal Polishing Certificate

	Expanded Functions Dental Assistant	Allowed to perform specified restorative functions. Must hold an Arizona Expanded Function Restorative certification
Arkansas	Dental Assistant	No specific requirements to work under direct supervision of a licensed dentist
	Registered Dental Assistant	There are a variety of paths to becoming an RDA in Arkansas. One option is getting your CDA and then passing the Arkansas exam. As an RDA you'll be allowed to perform coronal polishing, operate radiographic equipment, and other duties not authorized for general Dental Assistants.
California	Unlicensed Dental Assistant	After minimal training, is allowed to perform basic supportive procedures under the direct supervision of a dentist
	Registered Dental Assistant	Extensive education and/or work experience plus approved training in radiation safety, coronal polishing, infection control, and basic life support is required, along with passing the state RDA exam.
	Registered Dental Assistant with Extended Functions	With extended functions certification, an RDA's duties can expand to include preliminary oral health evaluations, taking impressions, and more.
	Registered Dental Assistant in Extended Functions with additional training	With additional training and certification, an RDA will be allowed to make determinations regarding which radiographs to perform for new patients. They will also be allowed to place protective interim restorations.
	Dental Sedation Assistant	A dental sedation assistant is allowed to monitor patients undergoing general anesthesia or conscious sedation, with additional duties including administration of drugs through intravenous lines.

		Twelve months of dental assisting experience is required, plus additional training and examination.
	Orthodontic Assistant	Training and certification as an orthodontic assistant allows duties specific to working in an orthodontist's office.
Colorado	Dental Assistant	No specific requirements to work under direct supervision of a licensed dentist
Connecticut	Dental Assistant	Assistants must successfully the DANB infection control exam or an infection control assessment administered by a CODA-accredited dental education program in Connecticut.
	Expanded Function Dental Assistant	Must be a CDA (or Certified Orthodontic Assistant) and complete complete additional education and exam requirements.
Delaware	Dental Assistant	No specific requirements to work under direct supervision of a licensed dentist
District of Columbia	Level 1 Dental Assistant	Assistants must have a high school diploma and must complete a satisfactory course in dental radiography.
	Level 2 Dental Assistant	Must be a CDA or have completed another approved dental assisting education program. A course in dental radiography is also required.
Florida	On-the-Job Trained Dental Assistant	Performs basic supportive dental procedures under the supervision of a licensed dentist.
	Dental Assistant formally trained in expanded functions	Must complete a CODA-accredited dental assisting program or a program approved by the Florida Board.

	Dental Assistant formally trained in restorative functions	To perform intraoral restorative functions under supervision of a licensed dentist, an assistant must have graduated from an approved dental assisting program, document 2,400 hours of clinical work experience, and complete an accredited restorative functions training course approved by the Florida Board of Dentistry.
Georgia	Dental Assistant	No specific requirements to work under direct supervision of a licensed dentist.
	Expanded Duty Dental Assistant	A high school diploma, current CPR certification, and completion of a Georgia Board-approved course in expanded assisting duties (DANB's CDA will work) are required.
Hawaii	Dental Assistant	No specific requirements to work under direct supervision of a licensed dentist.
Idaho	Dental Assistant	No specific requirements to work under direct supervision of a licensed dentist.
Illinois	Dental Assistant	No specific requirements to work under direct supervision of a licensed dentist.
	Dental Assistant Qualified in Expanded Functions	To perform coronal scaling, coronal polishing, or to place and finish amalgam, composite, or interim restorations, must meet state requirements and work under the direct supervision of a dentist.
	Expanded Function Dental Assistant	Must complete approved training courses in expanded functions.
Indiana	Dental Assistant	No specific requirements to work under direct supervision of a licensed dentist.

	Dental Assistant Qualified in Coronal Polishing / Dental Assistant Qualified in Medicaments for the Control of Dental Caries / Dental Assistant Qualified in Administering Nitrous Oxide	Must complete certifications and (for medicaments and nitrous) have minimum one year experience.
Iowa	Dental Assistant Trainee	Must be a high school graduate and must apply for a certificate of trainee status.
	Registered Dental Assistant	Must have six months experience as an assistant or be a graduate of an approved assisting program, and must complete additional courses in infection control and hazardous materials.
	Basic Expanded Function Provider	Must be a graduate of a CODA-accredited program, hold a current DANB certification, or have a minimum of one year experience as a registered dental assistant.
	Certified Level 1 Provider	A registered dental assistant must complete a board-approved training program in all Level 1 expanded functions (gingival retraction, applying cavity liners and desensitizing agents, taking final impressions, placement of temporary filling materials, etc.).
	Certified Level 2 Provider	Must complete one year as a Level 1 provider and complete an approved training program in all Level 2 functions (placement and shaping of amalgam and adhesive restorative materials, placement of intracoranal temporary fillings, fitting of stainless steel crowns, etc.).
Kansas	Dental Assistant	No specific requirements to work under direct supervision of a licensed dentist.

	Dental Assistant with Expanded Duties Training	For coronal polishing, the assistant must undergo appropriate training by a licensed dentist. For coronal scaling, the assistant must complete an approved course of instruction. For administration and monitoring of nitrous oxide, the assistant must be certified in CPR and must complete an approved course of instruction at a CODA-accredited teaching program.
Kentucky	Dental Auxiliary	No specific requirements to work under direct supervision of a licensed dentist.
	Registered Dental Assistant	The assistant must be certified in CPR and the supervising dentist must attest to the assistant's competency in delegated procedures.
	Registered Dental Assistant Qualified in Coronal Polishing / Registered Dental Assistant Qualified in IV Placement	The assistant must complete board approved courses from qualified institutions.
Louisiana	Dental Assistant	No specific requirements to work under direct supervision of a licensed dentist.
	Expanded Duty Dental Assistant	Must complete an expanded duty program approved the the state board or an equivalent CODA-accredited program, and complete an approved radiography course.
Maine	Unlicensed Person	No specific requirements to work under direct supervision of a licensed dentist.
	Expanded Function Dental Assistant	Must hold current DANB CDA certification or an active dental hygiene license and complete expanded function dental assisting program approved by the state.

Maryland	Dental Assistant	No specific requirements to work under direct supervision of a licensed dentist. Additional training and experience requirements must be met to work under general supervision for a sealant program.
	Dental Assistant Qualified in General Duties	Must complete an approved 35-hour course relating to Maryland dental assisting duties as well as hold a DANB CDA or pass the Maryland General Dental Assisting Expanded Functions exam.
	Dental Assistant Qualified in Orthodontics	Must complete an approved 35-hour course relating to Maryland orthodontic dental assisting duties as well as hold a DANB COA or pass the Maryland General Orthodontic Assisting Expanded Functions exam.
Massachusetts	Dental Assistant Trained on the Job	Must be 18 years old or older, pass a course on CDC guidelines, and be CPR certified.
	Certified Assistant (CA) or Formally Trained Assistant (FTDA)	For CA, must be DANB certified as CDA, COA, CPFDA, or CRFDA or hold certification from another approved certifying body. For FTDA, must have completed an approved CODA program.
	Expanded Function Dental Assistant	Must hold DANB certification and complete a formal CODA program in Massachusetts expanded functions.
Michigan	Dental Assistant	No specific requirements to work under direct supervision of a licensed dentist.
	Registered Dental Assistant	Must be certified by an accredited CODA dental assisting program that meets Michigan Board of Dentistry requirements and pass Michigan Board comprehensive and clinical exam.

Minnesota	Dental Assistant	Must be CPR certified and comply with current infection control guidelines to work under direct supervision of a licensed dentist.
	Licensed Dental Assistant (LDA)	Must be certified by an approved DANB CDA program and pass Minnesota licensing exam.
	Licensed Dental Assistant with Collaborative Practice Authorization	A LDA may enter into a collaborative agreement with a licensed dentist to perform specified dental assisting services without direct dental oversight in a health care facility, program, or nonprofit organization.
Mississippi	Dental Assistant	Must be CPR certified within 180 days of employment to work under direct supervision of a licensed dentist.
Missouri	Dental Assistant	No specific requirements to work under direct supervision of a licensed dentist.
	Expanded Functions Dental Assistant	Must be certified by approved DANB or CODA program with Missouri Dental Board approved expanded function training.
Montana	Dental Auxiliary	Must graduate from a CODA dental assisting program or receive instruction and training by a license dentist or board-approved continuing education course.
	DANB Certified Dental Assistant (CDA)	Must hold DANB CDA certification.
Nebraska	Dental Assistant	No specific requirements to work under direct supervision of a licensed dentist. Must be CPR certified to monitor nitrous oxide or assist in administration of anesthesia or sedation.

	Dental Assistant Qualified in Coronal Polishing	Must graduate from CODA-accredited course that includes coronal polishing, or complete 1,500 hours of work experience as a dental assistant and pass an approved course in polishing procedures.
	Licensed Dental Assistant (LDA)	Must graduate from a CODA-accredited course or have equivalent work experience and pass Nebraska Board of Dentistry exams.
	Expanded Function Dental Assistant (EFDA)	Must complete 1,500 hours work experience as an LDA and complete approved expanded functions coursework.
Nevada	Dental Assistant	No specific requirements to work under direct supervision of a licensed dentist. The dentist must attest that the assistant has had adequate training in infection control.
New Hampshire	Traditional Dental Assistant	No specific requirements to work under direct supervision of a licensed dentist.
	DANB Certified Dental Assistant (CDA) and Graduate Dental Assistant (GDA)	Must be a Graduate Dental Assistant or DANB CDA.
	Dental Assistant Qualified to Perform Expanded Duties	Must be a Graduate Dental Assistant or DANB CDA or pass an introductory course and qualify in infection control; and must meet specific course, certification, or experience requirements for each expanded function.
	Expanded Function Dental Auxiliary (EFDA)	Must be a registered dental hygienist, hold a DANB CDA, or be a graduate of a CODA-accredited program; and must have a minimum 4,500 hours of clinical experience; and must complete an approved EFDA course in dental restorations; and must be certified in basic life support.

New Jersey	Unregistered Dental Assistant	No specific requirements to work under direct supervision of a licensed dentist.
	Registered Dental Assistant (RDA)	Must pass DANB CDA or COA exam and graduate from an approved CODA-accredited assisting program or have two years work experience as a dental assistant and pass an approved program in expanded functions.
	Orthodontic Assistant (RDA)	Must pass an approved dental assisting program or have at least two years experience as a dental assistant; and must pass DANB's COA exam, topical fluoride exam, and coronal polish exam.
New Mexico	Dental Assistant	No specific requirements to work under direct supervision of a licensed dentist.
	Dental Assistant with State Certification in Expanded Functions	State certification including education and/or work experience is required for coronal polishing and pit and fissure sealants.
	Expanded Function Dental Auxiliary	Approved EFDA coursework is required, and must pass EFDA clinical exam. Must be certified in radiography, coronal polishing, and pit and fissure sealant expanded functions.
	Community Dental Health Coordinator	Must have expanded functions certifications and complete an approved CDHC program.
New York	Dental Assistant with a Limited Permit	Must complete an approved dental assisting program or alternative course of study. Limited permit allows for supervised work experience before taking and passing required exams.
	Registered Dental Assistant	Must complete approved course of study plus 200 hours of clinical experience, or alternative course of study that includes at least 1,000 hours of work experience. Must pass DANB's CDA exam or New

		York's Professional Dental Assisting exam; and must pass DANB's Radiation, Health, and Safety (RHS) and Infection Control (ICE) exams
North Carolina	Dental Assistant I (DA I)	No specific requirements to work under direct supervision of a licensed dentist. To monitor patients under nitrous oxide, must complete an approved seven-hour course.
	Dental Assistant II in Training (DA II in Training)	Training consists of 3,000 hours of chairside assisting under supervision of a licensed North Carolina dentist.
	Dental Assistant II (DA II)	Must complete an approved CODA-accredited assisting program or hold DANB CDA; or must complete 3,000 hours of full-time assisting employment and additional coursework in CPR, infection control, and office emergencies. Additional coursework required for coronal polishing or monitoring nitrous oxide.
North Dakota	Dental Assistant	Must have CPR certificate to work under direct supervision of a licensed dentist.
	Qualified Dental Assistant (QDA)	Must pass DANB's Radiation, Health, and Safety exam and Infection Control exam; must complete 650 hours of instruction including on-the-job training; and must pass examination on North Dakota laws and rules regarding dentistry.
	Registered Dental Assistant (RDA)	Must pass DANB's CDA exam or an approved CODA-accredited program.
	Registered Dental Assistant Qualified to Apply Pit and Fissure Sealants	Must be an RDA and successfully complete an approved course in sealants.

	Registered Dental Assistant with Restorative Functions Permit	Must be an RDA and successfully complete restorative functions coursework and training.
	Anesthesia Assisting	Must be an RDA and successfully complete additional training in anesthesia assisting.
Ohio	Basic Qualified Personel (BQP)	Trained directly by employer/dentist. Must show evidence of immunity/immunization against Hepatitis B. Additional training and work experience required to monitor nitrous oxide.
	Certified Assistant	Requires DANB CDA or certification by Ohio Commission on Dental Assistant Certification. Additional requirements for coronal polishing or pet and fissure sealants.
	Expanded Function Dental Auxiliary	Must be a certified assistant or dental hygienist and complete an approved EFDA training course and pass the EFDA exam. BLS certification also required.
Oklahoma	Dental Assistant	Must be adequately trained by the supervising dentist and must pass a background check.
	Dental Assistant with Expanded Function Permit	Must complete training in expanded functions at CODA-accredited program.
	Oral Maxillofacial Surgery Assistant	Must complete six months of training followed by completion of the Dental Anesthesia Assistant National Certification Exam.
Oregon	Dental Assistant	No specific requirements to work under direct supervision of a licensed dentist.
	Expanded Function Dental Assistant (EFDA)	Must complete a CODA-accredited assisting program or pass the DANB CDA exam and hold an Oregon certificate of radiologic proficiency.

	Expanded Function Dental Assistant (EFDA) with Restorative Functions	An Expanded Function Dental Assistant must complete additional coursework and training for certification in restorative functions.
	Expanded Function Orthodontic Dental Assistant (EFODA)	For expanded orthodontic functions, an EFDA must have additional training and pass the Oregon Expanded Functions/Orthodontic Assisting exam.
	Expanded Function Preventive Dental Assistant (EFPDA)	Coursework and proficiency in radiology, infection control, and coronal polishing are required.
	Anesthesia Monitor	Must be certified in BLS/CPR and receive training in monitoring patients under sedation and assisting with procedure, problems, and emergencies.
	Anesthesia Assistant with IV Therapy Certificate	Must complete an approved course in intravenous access or phlebotomy.
Pennsylvania	Dental Assistant	No specific requirements to work under direct supervision of a licensed dentist.
	Expanded Function Dental Assistant	Must graduate from an expanded function dental assisting program, a CODA-accredited hygiene school, or complete an approved state certification program.
Rhode Island	Dental Assistant	Must hold a Basic Life Support certificate and complete on hour per year of infection control training.
	DANB Certified Assistant	Must hold a DANB CDA, COA, CPFDA, CRFDA, COMSA, or CDPMA.
	DAANCE Certified Maxilofacial Surgery Assistant	Must complete an approved program fo Dental Anesthesia Assistants National Certification Exam

		(DAANCE) and complete an approved cardiac life support course.
South Carolina	Dental Assistant	No specific requirements to work under direct supervision of a licensed dentist. Must be CPR certified to work in settings where sedation is administered.
	Expanded Duty Dental Assistant (EDDA)	Must graduate from a CODA-accredited assisting program or complete two years of continuous full-time employment as a chairside dental assistant.
South Dakota	Unlicensed Dental Assistant	No specific requirements to work under direct supervision of a licensed dentist.
	Registered Dental Assistant (RDA)	Must hold DANB CDA or graduate from an approved dental assisting program. Must be CPR certified.
	Analgesia, Sedation, and Anesthesia Assisting	Must have Basic Life Support certification and complete an approved course in anesthesia assisting.
Tennessee	Practical Dental Assistant	Must be currently receiving practical chairside dental assisting training.
	Registered Dental Assistant (RDA)	Must successfully complete BLS and CPR or equivalent courses and complete the Tennessee Board of Dentistry Ethics and Jurisprudence exam.
	Registered Dental Assistant Qualified to Perform Expanded Functions	Must complete coursework for coronal polishing, sealants, nitrous oxide, and/or restorative/prosthetic functions.
Texas	Dental Assistant	No specific requirements to work under direct supervision of a licensed dentist.

	Dental Assistant Qualified to Perform Expanded Functions	For coronal polishing or pit and fissure sealants, two years work experience is required plus additional coursework.
	Registered Dental Assistant (RDA)	A DANB CDA or completion of course of study approved by the Texas State Board of Dental Examiners is required.
Utah	Dental Assistant	Dental assistants must have current CPR or BSL certification.
Vermont	Traditional Dental Assistant	Must complete emergency office procedures training within six months of hiring.
	DANB Certified Dental Assistant (CDA) with State Certification	Must hold DANB CDA and be employed by a licensed Vermont dentist.
	Expanded Function Dental Assistant (RDA)	A CDA or licensed dental hygienist must complete training in CODA-accredited program for any expanded function.
Virginia	Dental Assistant I (DA I)	No specific requirements to work under direct supervision of a licensed dentist. For administration or monitoring of anesthesia or sedation, must be certified in basic cardiac life support or be certified as an anesthesia assistant.
	Dental Assistant II (DA II)	Must hold DANB CDA and complete board-approved expanded functions requirements from a CODA-accredited program.
Washington	Registered Dental Assistant (RDA)	Must hold BLS certification and complete seven hours of AIDS education and training.
	Expanded Function Dental Auxiliary (EFDA)	Must have DANB CDA or be a graduate of CODA-accredited program. Must also complete an

		approved EFDA course and pass restorative and clinical exams.
	Dental Anesthesia Assistant	Must complete the Dental Anesthesia Assistant National Certification Exam, California's Orala and Maxillofacial Surgery Assistant's Course, or approved equivalent training.
West Virginia	Dental Assistant	No specific requirements to work under direct supervision of a licensed dentist.
	Dental Assistant Qualified in Expanded Duties	Training and certification is required for nitrous oxide monitoring, coronal polishing, and other expanded duties.
	Qualified Monitor	To work as a Qualified Monitor, training is required in recognition and treatment of medical emergencies, monitoring of vital signs, and operation of related equipment. BLS/CPR certificate is required.
Wisconsin	Unlicensed Person	Any dentist who delegate any remediable dental procedure or function to an unlicensed person must first provide training to or verify the competence of the person.
Wyoming	Dental Assistant	Dental assistants maybe trained by their employer or an approved program.
	Dental Assistant Qualified in Placement of Pit and Fissure Sealants	Must complete an approved pit and fissure sealants course or a CODA-accredited dental hygiene or dental assisting program.

5/21/2025 Summary of Registered Dental Assistants in Idaho, Washington, California, Utah, and Nevada

Idaho Registered Dental Assistants: No

A dental assistant in Idaho may perform dental services for which they are trained and which are not prohibited under the direct supervision of a licensed dentist.

There are no specific education or training requirements.

To administer nitrous oxide/oxygen to patients, a dental assistant must be trained in accordance with Idaho Board of Dentistry rules.

There are no radiography requirements for dental assistants in the state of Idaho.

All dental assistants may legally operate dental X-ray equipment and perform dental radiographic procedures.

Washington State Registered Dental Assistants: Yes

Every dental assistant in the state of Washington must be registered. To be eligible for registration as a dental assistant, one must:

1. Provide a completed application on forms provided by the Washington State Dental Quality Assurance Commission (DQAC), AND
2. Pay applicable fees (currently $40), AND
3. Provide any other information determined by the Washington State Dental Quality Assurance Commission.

The dental assistant registration must be renewed annually on or before the dental assistant's birthday. Annual renewal fee is currently $25.

A registered dental assistant must hold a current and valid health care provider basic life support (BLS) certification.

A registered dental assistant in the state of Washington may earn an endorsement in sealant/fluoride varnish solely for the purpose of treating children in school-based and school-linked programs.

Registered dental assistants monitoring patients receiving deep sedation or general anesthesia must receive a minimum of 14 hours of documented training in a course specifically designed to include instruction and practical experience in the use of equipment.

California Registered Dental Assistants: Yes

Registered dental assistants must satisfactorily complete twenty-five (25) Continuing Education (CE) units. Application fee is currently $120. With passage of Senate Bill 1453 in 2024 by the California State Legislature, current requirements for registering as a dental assistant (RDA) are effective until July 1, 2025. Beginning July 1, 2025, new amended requirements and alternative pathways for RDA eligibility will go into effect.

Renewal Fees

The table below includes the fees for RDA, Registered Dental Assistant in Extended Functions (RDAEF), Dental Sedation Assistant (DSA), and Orthodontic Assistant (OA) permit renewal, as well as information on delinquency (late) fees.

License/Permit	Fee	Late Fee (Delinquent Fee)	Date of Delinquency
Registered Dental Assistant (RDA)	$100.00	$50.00	30 days after expiration
Registered Dental Assistant in Extended Functions (RDAEF)	$100.00	$50.00	30 days after expiration
Dental Sedation Assistant (DSA)	$100.00	$50.00	30 days after expiration
Orthodontic Assistant Permit (OA)	$100.00	$50.00	30 days after expiration

Three New Pathways Established to Qualify for RDA licensure

- Certified Dental Assistant Pathway
- The Alternative Dental Assisting Program Pathway
- The Preceptorship in Dental Assisting Pathway

Pit and Fissure Sealants Certificate Required with Application

- As of July 1, 2025, all applicants will be required to submit a copy of their completion certificate for a Board-approved pit and fissure sealants course with the Registered Dental Assisting Examination and Licensure Application.

For those applying for RDA licensure, Orthodontic Assistant (OA) permits, and Dental Sedation Assistant (DSA) permits, there are new expiration dates assigned to course completion certificates. They are as follows:

- The Dental Practice Act and Infection Control course certificates must indicate the course was completed within 2 years of the application date.
- Coronal Polishing, pit and fissure sealants, and ultrasonic scaling certificates must indicate the course was completed within 5 years of the application date.
- Radiation Safety certificates must indicate the course was completed within 10 years of the application date.

Utah Registered Dental Assistants: No

A dental assistant in the state of Utah may perform basic supportive dental procedures under the supervision of a licensed dentist.

All dental assistants must have current CPR or Basic Cardiac Life Support (BCLS) certification.

In the state of Utah, a dental assistant must:

1. Complete a dental assisting course from a CODA-accredited program, OR

2. Pass the national DANB Radiation Health and Safety (RHS) exam, OR

3. Complete a radiology course and exam approved by the Utah Dentist and Dental Hygienist Licensing Board that covers the topics found in Board rules.

Nevada Registered Dental Assistants: No

The Nevada State Board of Dental Examiners does not license dental assistants in radiation health, safety, and administration. Rather, each licensed dentist must, with his or her application for license renewal, include a certified statement containing the name and position of each dental assistant who assists in radiographic procedures, the date each dental assistant began to assist in radiographic procedures, and a statement attesting that each such dental assistant is qualified to operate radiographic equipment and has received all of the following:

1. Adequate instruction in radiographic procedures, *AND*

2. Training in CPR at least every two years while employed, *AND*

3. A minimum of four hours of continuing education in infection control every two years while employed, *AND*

4. Before commencing performance of radiographic procedures, a copy of the Nevada statutes and regulations governing dentistry.

Per legislation signed in 2023 (SB 310), Nevada will begin requiring successful completion of DANB's CDA certification for the newly recognized expanded function dental assistant level. Although the effective date of the bill is 1/1/2024 and the Nevada State Board of Dental Examiners has drafted rules to implement this new law, the new rules are not yet finalized and effective.

Thoughts on OPA's being introduced in Oregon

I have been asked why I do not support OPA's in Oregon if I support DA career advancement opportunities such as RFC and LAFC.

Two different categories of functions:

1) Restorative functions support patient restoration procedures. One subject, one function, curriculum allows for DA's and DH's to grow their careers within the frame work of a single function that requires specific concise education and training to support the dentist with restorations. These clearly increase treatment efficiency by reducing the dentist chair time with patients. This allows for increased patient access; more time, more openings in the schedule. It allows the dentist to focus on diagnosis, treatment planning and execution of the restoration preparation, process and an end result.

2) Periodontology is a broader subject that must include expanding knowledge beyond one function; scaling supragingival calculus. Advanced knowledge and understanding of the supporting periodontal tissues, diseases, treatment options and skills practice would be required for a DA to be prepared for the variety of implications and potential injuries that could occur to the periodontal structures when scaling teeth. I believe referring to Dental hygiene educators who have the expertise and explanations as to why this is not a good idea is who we should listen to.

How will the OPA services be billed? Will they receive the same pay as the DH who performs the same functions?

This is a shortage issue. If there is a shortage of DH's and DA's and if DA's are trained to assist a dental hygienist does that not add to the shortage of DA's? Rob Peter to pay Paul? How will this benefit a dental practice?

As a long-time, experienced dental assisting instructor, most of what I learned from DA's who become DH's is not because they want to give up their role of supporting dentists during restorative procedures but because they need to make a living wage to support their families and they want to gain more respect in the dental community. If DA's can acquire additional certifications to support the dentist and increase access to care for their patients while increasing their pay and benefits, I think many who chose to move on to hygiene would not have done so. Of course, there are those who focused on dental hygiene from the beginning and that was their end goal.

Research and data collection is needed to further our understanding of why there is a shortage. The discussion about the shortage of dental assistants and hygienists tends to revolve around anecdotal examples. Data that identifies dental practices that are struggling to fill their DA and

DH positions is needed. I think it is important we obtain accurate information before we make assumptions that an OPA will solve the problem.

Two final thoughts….if we go back to the 2022 Workforce Shortage Study that was completed by ADA, ADHA and DANB, *"the data results show that factors associated with attrition include negative workplace culture, insufficient pay, lack of growth opportunity, inadequate benefits, and feeling overworked."* I believe these factors to be the core reasons for the shortage and further study is what we should be doing…not putting a band aide on the problem. We need to address the real issues and avoid the anecdotal stories to determine the best approach.

Meanwhile the Oregon RFC's and LARC's can support the dental practices in a positive way and may even retain a few dental assistants in the profession while we continue to discuss what their pay should be and how their contribution may benefit access to care.

For those who think OPA is a great idea that came from the military and "…what's good for soldiers is good for the civilian population", please read *Adopting substandard military preventive dentistry models is not the answer to solving the dental hygiene workforce shortage* article in Dental IQ written by an Army Preventive Dentistry Specialist, now a registered dental hygienist.

In addition, here is another excellent Dentistry IQ article that discusses proper CDT Procedure codes for Oral Preventive and Scaling Dental Assistants.

Ginny Jorgensen

Alana Hall, MHA, RDH, in military service

DENTAL HYGIENE

Adopting substandard military preventive dentistry models is not the answer to solving the dental hygiene workforce shortage

In this article, a dental hygienist and former Army Preventive Dentistry Specialist shares firsthand insights into why the military's fast-paced, readiness-focused model may appear efficient but falls short in promoting long-term oral health. Discover why adopting similar models in civilian settings could compromise patient safety, ethical standards, and care quality—and what we should advocate for instead.

Alana Hall, MHA, RDH July 24, 2025 12 min read

Attachment #12

What you'll learn in this article

- Why the military dental model focuses on short-term readiness—not long-term prevention—and why that matters in civilian care settings
- How relying on minimally trained personnel for preventive procedures can result in missed disease, fragmented care, and delayed treatment
- What legal and ethical risks arise when underqualified providers perform duties outside their scope, especially regarding insurance billing and patient safety
- Why adopting military-style care models in civilian or Medicaid populations may deepen health inequities instead of solving access issues

A perspective from an Army Preventive Dentistry Specialist, now Registered Dental Hygienist

As the health-care industry increasingly recognizes oral health as a critical component of overall health and well-being, conversations around access, efficiency, and cost have intensified. While these discussions are necessary, they sometimes lead to the suggestion of adopting scaled down, "efficient" models that appear to work in other systems, such as the Army's Preventive Dentistry Specialty model. However, what may appear to work in a battlefield-readiness framework is not appropriate for a civilian population.

Having served in the United States Army for nine years as a Dental Specialist and as a Preventive Dentistry Specialist and now practicing as a licensed Registered Dental Hygienist, I have firsthand experience in both systems. Over the last 15 years, my career has spanned military, academic, and civilian health-care environments. I have worn many hats and have worked as a dental assistant, preventive dentistry specialist, expanded duties dental assistant, clinical care coordinator, and RDH. I've led transitions within practices, managed clinical training, and built and operated a forward mobile dental clinic in Afghanistan. I have remained flexible in the face of change throughout my career, and I have learned what works and what does not. While the military dental model has a clear purpose within its unique environment, it is not designed to support lifelong oral health, and it should not be used as a template for civilian care.

Alana Hall, MHA, RDH, in military service

Military dentistry: Efficient by necessity, not by design

The Army dental mission is primarily focused on ensuring that service members are "deployable" and to reduce noncombat dental casualties during deployment or other assigned missions.[1] In the Army, this metric is referred to as readiness and is tracked through the Medical Protection System (MEDPROS).[2] The priority is immediate or urgent interventions to prevent dental emergencies in combat zones. It does not emphasize long-term prevention or the comprehensive management of chronic oral diseases.

Despite these known limitations, there have been recent public endorsements of implementing military-style models in civilian care.

Attachment #12

In a 2025 episode of the *Straight Up with Steph* podcast, American Dental Association President Brett Kessler, DDS, stated, "If it is good enough for our soldiers in the military and battle ready, I think we could do this [in] the public too."[3] While this sentiment may be rooted in a desire to improve access, it reflects a fundamental misunderstanding of both the military's dental mission and the broader needs of civilian populations.

The origins of the Army's Preventive Dentistry Specialist program date back to the 1960s, with formal training courses first appearing in 1961. However, the designation became more structured in the early 2000s and was officially recognized under the updated 68E Dental Specialist Military Occupational Specialty (MOS) in 2006.[4] The expanded preventive role was implemented largely in response to a persistent shortage of licensed dental hygienists in military settings and the increasing demand to keep large troop populations dentally deployable. Rather than invest in expanding the number of licensed providers, the Army created a preventive function staffed by enlisted personnel with limited training.

While this model addressed immediate staffing gaps and increased the volume of basic preventive services, it has not led to measurable improvements in patient outcomes. Chronic conditions often go unmanaged, and many patients receive fragmented care or are deferred to delayed recall cycles. This model was a logistical solution to a personnel issue—not a clinical strategy rooted in evidence-based prevention.

Training to become a Preventive Dentistry Specialist (identified as "X2") in the Army consists of a 12-week course that includes training in oral hygiene prophylactic procedures, applying pit and fissure sealants to the teeth, evaluating dental radiographs, and cleaning and sterilizing dental instruments and equipment.[5] The clinical scope of an X2 includes performing basic prophylactic services (D1110), applying topical fluoride varnish, applying pit and fissure sealants, and providing oral hygiene instructions. Their clinical work is limited to patients who present with a Periodontal Screening and Recording (PSR) score of 0 to 2. If a patient shows signs of radiographic calculus or clinical indicators of periodontal disease, they are considered outside the X2's scope of practice. In those cases, the patient typically receives a full-mouth debridement, or FMD (D4355), to remove the bulk of deposits and is then scheduled for a follow-up visit with a civilian RDH for comprehensive periodontal charting, diagnosis, and treatment planning.

These structural limitations are also compounded by the demographics of the military patient population. Many service members enter military service with limited education, a low dental IQ, low motivation for oral self-care, and inconsistent access to preventive services. This often results in heavy calculus buildup, gingival inflammation, and early to moderate periodontal disease, even among young, otherwise healthy individuals. Truly "healthy" patients, with minimal clinical findings and excellent home-care habits, are rare. Yet the system is designed for high-volume throughput and relies heavily on minimally trained personnel. As a result, patients with complex needs are often inadequately assessed and treated, leading to worsening conditions that could have been prevented with early intervention.

The recall standard in the Army is annual for most service members, regardless of their risk status.[2] More frequent recall is typically assigned to patients diagnosed with active periodontal disease and those in periodontal maintenance, where they may be on a three-, four-, or six-month recall. However, access to specialty care is limited. A referral to a periodontist requires that the disease be advanced, and the patient must undergo a screening process before the case is accepted. Full-mouth periodontal charting is not

routinely performed unless the patient is actively being treated by or referred to a periodontist, leaving many early cases undocumented and untreated.

There is a demand for productivity in Army dentistry, as with any health-care practice that is following metrics, with an emphasis on meeting readiness as their metric and processing as many patients as possible in a limited time frame. This focus on volume often comes at the expense of clinical thoroughness, individualized care, and early disease management. Patients who need more time, deeper assessments, or multiple visits are frequently deferred until their next recall cycle, by which time conditions may have progressed.

Ultimately, dental hygiene care in the Army is structured around volume, compliance, and operational readiness. It is not built on a foundation of personalized, relationship-based care. The emphasis on speed and documentation often replaces thorough clinical evaluation, tailored patient education, and consistent follow-up. These are elements that are essential for effective, long-term oral health care.

Civilian dentistry requires higher standards

In contrast to the military model, civilian RDHs operate within a care framework that is patient-centered, evidence-based, and prevention-focused. Most hygienists must graduate from accredited educational programs, meet rigorous licensure requirements, maintain continuing education, and adhere to protocols that emphasize early detection, risk assessment, and interprofessional collaboration. Their training equips them to provide comprehensive, individualized care grounded in both clinical science and ethical standards.

Efforts to expand access to care should never come at the expense of clinical integrity. Lowering the bar in the name of access is not a sustainable solution; it is a short-sighted compromise that often increases health disparities instead of reducing them. Patients in marginalized or underserved communities deserve the same standard of high-quality, evidence-based care as any other population. Increasing the number of patient encounters by using minimally trained providers may appear to address volume, but it frequently fails to resolve the root causes of poor oral health. True access means equitable access to quality care, not simply more care.

There are also significant insurance reimbursement and legal implications when undertrained providers are introduced into civilian practices under titles like “scaling assistants.” In the Army, if a patient seen by an X2 required treatment beyond their scope, a second appointment with an RDH was necessary. This often resulted in a full-mouth debridement (FMD) being coded. In the civilian sector, such a scenario could present challenges with insurance frequency limitations, especially if the patient had previously received a debridement within a limited time frame.

Kathy Forbes, BS, RDH, addressed this in *RDH* magazine, clarifying that the correct CDT code for services performed by a “scaling assistant” is D1999, the miscellaneous preventive code. However, once dental offices realize how low the reimbursement is for this code, there may be financial pressure to use higher-paying procedure codes that the assistant is not legally permitted to perform. This creates the risk of insurance fraud, placing both providers and practices in legal jeopardy and undermining the ethical foundation of dental care.[6]

Some states exploring or piloting “scaling assistant” models have justified their implementation by claiming they are meant specifically for their Medicaid population.[7] This justification is deeply troubling. Patients with

public insurance deserve the same level of care and clinical oversight as those with private coverage. Creating a separate, lower standard of care based on insurance status is not only discriminatory but also unethical and harmful to public trust. Moreover, allowing unlicensed or underqualified individuals to provide procedures outside their legal scope, even if billed under the supervising dentist's National Provider Identifier (NPI), may constitute a violation of the False Claims Act. Submitting claims for services rendered by unqualified personnel is not only deceptive but also subject to legal action, including audits, penalties, and reputational harm.[8,9] Innovation must never come at the expense of compliance, ethical standards, or patient safety.

Incorporating elements of the Army Preventive Dentistry Specialist model, such as authorizing undertrained personnel to perform procedures beyond their preparation, undermines the progress made in preventive oral health care. Although such measures may seem efficient on paper, in practice they often result in missed diagnoses, disease progression, and increased long-term health-care costs.

A system built for combat readiness is not built for wellness

I am proud of my military service and of what my colleagues and I accomplished under challenging conditions. The Army's dental model is effective in its own context, often operating in fast-paced, resource-limited, and unpredictable environments. However, we must not confuse a system designed for battlefield readiness with one designed to promote lifelong oral and systemic health. This model is necessarily structured around urgency, readiness, and resource conservation. It is reactive rather than preventive and prioritizes functionality over long-term health outcomes.

In contrast, a patient-centered care model emphasizes individualized treatment, early intervention, shared decision-making, and continuity of care. It values not only clinical outcomes, but also the patient's experience, understanding, and participation in their own oral health. Civilian dental care is built on these principles, recognizing that lasting wellness is achieved through education, consistent maintenance, and evidence-based intervention, not rushed procedures or one-size-fits-all protocols. A true patient-centered model requires time, training, and a qualified dental workforce, not short-term fixes or improvised solutions adapted from military structures.

Rather than adopting stripped-down care models, we should focus on strengthening access to the systems that work. This includes increasing support for licensed dental hygienists, investing in preventive services in underserved areas, improving clinical infrastructure, and fostering interprofessional care teams.

Conclusion

The future of oral health care should be guided by clinical excellence, ethical integrity, and a firm commitment to health equity. Importing elements of the military or, specifically, the Army Preventive Dentistry Specialist model, especially those designed for high-volume, low-touch care, poses a real threat to those principles. What may be efficient in the context of combat readiness is not appropriate in environments where prevention, patient education, and continuity of care are essential to long-term wellness.

Rather than lowering our expectations or expanding the responsibilities of undertrained personnel, we must advocate for solutions that enhance the quality of care for all. This includes investing in licensed dental

hygienists, supporting integrated and interprofessional care models, increasing access in underserved communities, and leveraging innovation without sacrificing ethics or clinical safety.

Patients, regardless of insurance status, zip code, or background, deserve thoughtful, individualized care that recognizes the deep impact of oral health on their overall health and quality of life. Cutting corners in the name of cost or access will only lead to a system where preventable conditions become chronic, and underserved populations are treated with a lower standard of care.

Let us resist the temptation to adopt what is simply fast or familiar and instead commit to what is right. We must hold the line on standards, protect the integrity of our profession, and demand that every patient receives care worthy of their trust.

Disclosure: The views and opinions presented herein are those of the author and do not necessarily represent the views of DoD or the Army. Appearance of, or reference to, any commercial products or services does not constitute DoD or Army endorsement of those products or services. The appearance of external hyperlinks does not constitute DoD or Army endorsement of the linked websites, or the information, products or services therein.

Editor's note: This article first appeared in *Clinical Insights* newsletter, a publication of the Endeavor Business Media Dental Group. Read more articles and subscribe.

References

1. Army Regulation 40-35 Medical Services: Preventive Dentistry and Dental Readiness. 2025. https://milreg.com/File.aspx?id=6
2. Army Regulation 600-8-101 Personnel Readiness Processing. https://milreg.com/File.aspx?id=1326
3. Workforce shakeups & the future of dentistry with ADA President. Straight Up With Steph podcast. YouTube. June 9, 2025. https://www.youtube.com/watch?v=Oj3nL0V2ASo&list=PLMqvRkdI4s6FvkLIlYThqWX2b5InmTkKb&index=4
4. Highlights in the history of Army dentistry. The Free Library. 2015. https://www.thefreelibrary.com/Highlights%2Bin%2Bthe%2Bhistory%2Bof%2BArmy%2Bdentistry.-a0253627594?utm_
5. S. Army Medical Department Center and School Course Catalog 2018. https://medcoeckapwstorprd01.blob.core.usgovcloudapi.net/pfw-images/dbimages/AMEDDC&S%20Catalog%20FY18%20draft%20as%20of%2014%20SEPT%202017.pdf
6. Forbes KS. Are D1110/D1120 the proper CDT procedure codes for oral preventive assistants/ scaling assistants? *RDH*. July 1, 2025. https://www.rdhmag.com/patient-care/dental-coding/article/55300647/are-d1110-d1120-the-proper-cdt-procedure-codes-for-oral-preventive-assistants-scaling-assistants
7. Anderson O. Arizona oral preventive assistants bill becomes law. *ADANews*. April 3, 2025. https://adanews.ada.org/ada-news/2025/april/arizona-oral-preventive-assistants-bill-becomes-law/
8. The False Claims Act: A Primer. Justice.gov. 2010. https://www.justice.gov/sites/default/files/civil/legacy/2011/04/22/C-FRAUDS_FCA_Primer.pdf
9. Federal False Claims Act. Dentist's Advantage. 2025. https://www.dentists-advantage.com/Prevention-Education/Risk-Alerts/Risk-Alerts-Index/Content/FEDERAL-FALSE-CLAIMS-ACT

Attachment #12

About the Author

Alana Hall, MHA, RDH

Alana Hall, MHA, RDH, is a mission-driven dental professional with over 15 years of experience in military, academic, and civilian dental settings. A U.S. Army veteran...

Show more

DENTAL CODING

Are D1110/D1120 the proper CDT procedure codes for oral preventive assistants/scaling assistants?

How do practices ethically and accurately code supragingival scaling by dental assistants, and avoid misrepresenting care and risking insurance fraud? Find out from coding expert Kathy Forbes.

Kathy S. Forbes, BS, RDH July 1, 2025 4 min read

What you'll learn in this article

- How to code supragingival scaling performed by dental assistants.
- Why D1999 is appropriate for coronal scaling documentation.
- The evolution of CDT code descriptors for prophylaxis procedures.
- Risks of misusing D1110 or D1120 in documentation.
- Ethical coding practices per ADA guidelines and definitions.

Question: Dental assistants in several states can now perform a prophylaxis. How do offices code this for documentation and insurance purposes? What is the CDT procedure code if an assistant is allowed to scale supragingivally?

Answer: The quick answer is that if a hygienist or dentist does **not** need to complete any subgingival scaling on the patient, the most appropriate would be D1999 with a narrative of “coronal scaling on an adult” or “coronal scaling on a child.”

Often the next question is: Why not select D1120 (child prophylaxis on primary or transitional dentition) or D1110 (adult prophylaxis on permanent or transitional dentition)?

The response to this is that both procedure codes' descriptors begin with "removal of plaque, calculus, and stains from the **tooth structures** and implants," **not** just the supragingival/coronal part of the tooth. But it hasn't always been this way.

It's important to understand how the ADA defines "coronal" and "clinical crown." From the Glossary of Dental Clinical Terms: Coronal refers to the crown of a tooth, and clinical crown is that portion of a tooth **not** covered by tissues.

The Code Maintenance Committee, under authority of the Council on Dental Benefit Programs, is very deliberate and specific when it comes to developing procedure code descriptors. They try to be as precise as possible when it comes to creating procedure codes, and even more specific when it comes to amending current procedure codes.

The first time descriptors were included in the manual was in *CDT-2 1995-2000,* and the decision was made to identify that the prophylaxis procedure involves only removing plaque, calculus, and stains *supragingivally on the clinical crown.*

D1110 prophylaxis–adult: A dental prophylaxis performed on transitional or permanent dentition that includes scaling and polishing procedures to **remove coronal** plaque, calculus, and stains. Some patients may require more than one

appointment or one extended appointment to complete a prophylaxis. A document is needed for additional time or appointments.

D1120 prophylaxis–child: A routine dental prophylaxis performed on primary or transitional dentition only.

PATIENT CARE

How a group of grassroot...

RDH MAGAZINE PODCAST

How to code for prophys...

For the next five years (2000-2005), there were subtle amendments to these codes, but the descriptors continued to state, "Remove **coronal** plaque, calculus, and stains." Thus, if either of these procedures were documented and billed as such, the clinician was stating they only removed deposits on that part of the tooth that was **not** covered by tissues, i.e., supragingival deposits **above the gumline**. But those of us in practice all know we did remove deposits subgingivally to the base of the sulcus as well.

When *CDT 2005-2006* was published, the descriptors were significantly changed to remove the word "coronal" since it became clear that hygienists were removing deposits subgingivally as well as supragingivally. The descriptors were amended to "tooth structures" to identify that the deposits were being removed down to the base of the sulcus, which hygienists had been doing for years!

D1110 prophylaxis–adult: Removal of plaque, calculus, and stains **from the tooth structures** in the permanent and transitional dentition. It is intended to control local irritational factors.

D1120 prophylaxis–child: Removal of plaque, calculus and stains **from the tooth structures** in the primary and transitional dentition. It is intended to control local irritational factors.

For the past 20 years, no significant amendments have been made to the prophylaxis procedure codes other than adding "and implants" in CDT 2021. The

current descriptors from CDT 2025, page 13 state:

D1110 prophylaxis–adult: Removal of plaque, calculus, and stains from the tooth structures and implants in the permanent and transitional dentition. It is intended to control local irritational factors.

D1120 prophylaxis–child: Removal of plaque, calculus, and stains from the tooth structures and implants in the primary and transitional dentition. It is intended to control local irritational factors.

In conclusion, since the legislation that has been passed in several states and proposed in other states limits oral preventive assistants/scaling assistants to remove deposits supragingivally (above the gumline), **there is no code for this specific procedure.** If there is no procedure code that accurately describes the service provided, a "D_999" code, or in this instance, D1999, would be appropriate with a narrative of "coronal scaling–adult" or "supragingival scaling–adult."

Submitting as D1110 or D1120 by an oral preventive assistant/scaling assistant—if no subgingival scaling was necessary by a dentist or hygienist—could be considered a false or misleading representation to an insurance carrier and the submission could be considered a fraudulent act.

As stated in the ADA Code of Ethics, Section 5, Principle Veracity (truthfulness): 5.B.5: Dental procedures: "A dentist who incorrectly describes on a third-party claim form a dental procedure in order to receive a greater payment or reimbursement or incorrectly makes a noncovered procedure appear to be a covered procedure on such a claim form is engaged in making an unethical, false, or misleading representation to such third party."

About the Author

Kathy S. Forbes, BS, RDH

Kathy S. Forbes, BS, RDH, has been a dental hygienist, educator, speaker, author, consultant, an...

Show more

Sign up for RDHMag Newsletters

Get the latest news and updates.

SIGN UP

Related

Ask a Pro: Your patient asks, "Why can dental assistants scale?"

Hygiene Mentor: How to carefully approach dental assistants about ultrasonic...

Voice Your Opinion!

Trending

Why critical thinking matters in dentistry's misinformation age

The young and the anticoagulated: A guide to blood thinners for today's dental hygienist

Tongue hygiene: Are you missing this critical third step?

LOAD MORE CONTENT

RDH

Since 1981, RDH magazine has been the premier resource for dental hygienists seeking clinical excellence, continuing education, and career advancement in oral health care.

Newsletters

The top stories, industry insights and relevant research, assembled by our editors and delivered to your inbox.

SIGN UP

Connect

Follow us for the latest industry news and insights.

Affiliated Brands

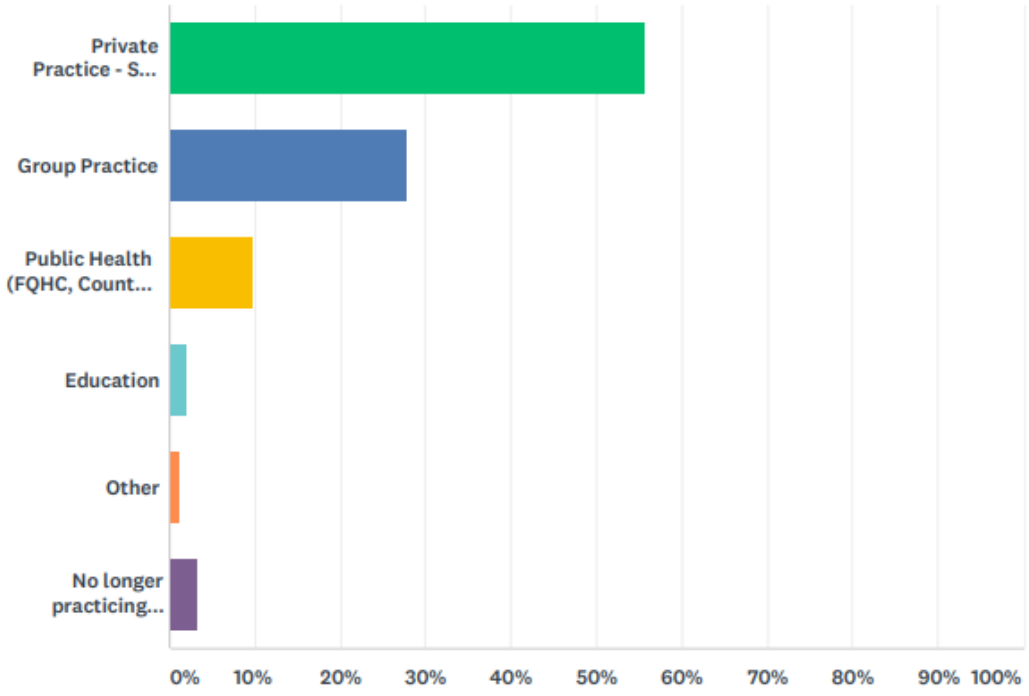
RDH UNDER ONE ROOF DENTAL ECONOMICS DENTISTRYIQ

PERIO-IMPLANT ADVISORY

Dentists - Dental Assistant Questionnaire

Q1 What type of setting do you primarily practice dentistry?

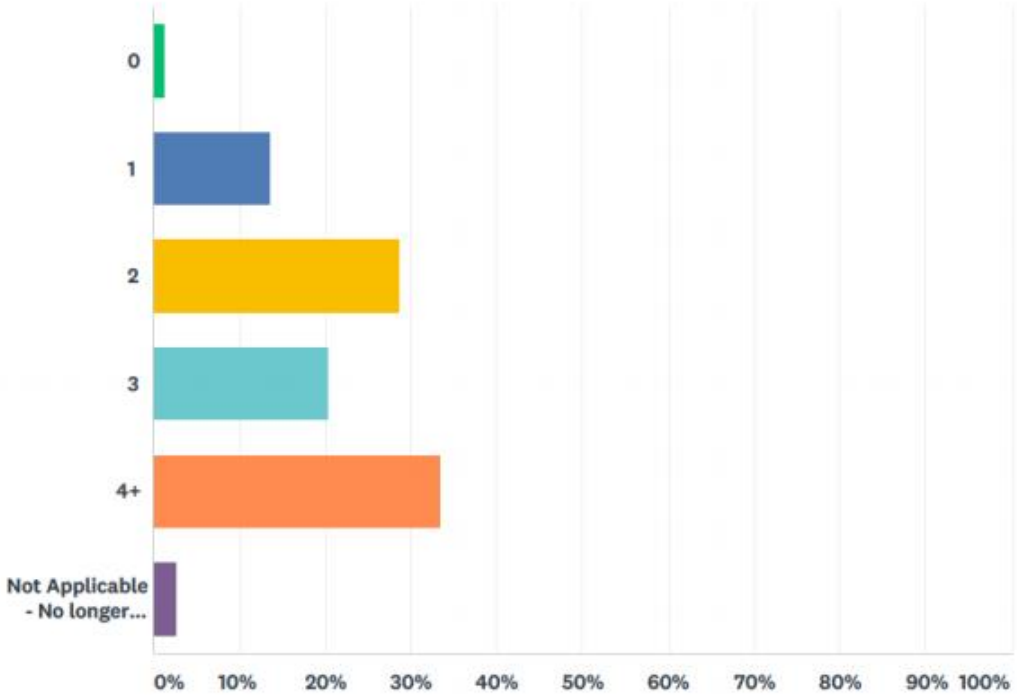
Answered: 472 Skipped: 0



ANSWER CHOICES	RESPONSES	
Private Practice - Sole Practitioner	55.72%	263
Group Practice	27.75%	131
Public Health (FQHC, County, Corrections, Community etc.)	9.75%	46
Education	2.12%	10
Other	1.27%	6
No longer practicing (Retired, Disabled etc.)	3.39%	16
TOTAL		472

Q2 How many dental assistants do you employ or work at your primary location?

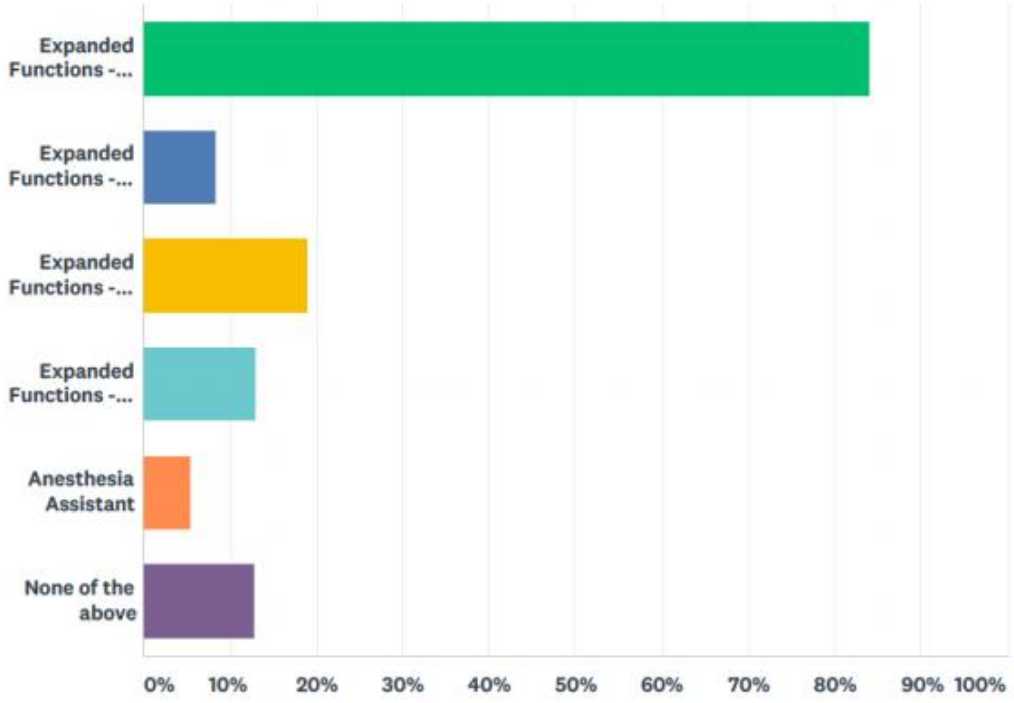
Answered: 469 Sk pped: 3



ANSWER CHOICES	RESPONSES	
0	1.28%	6
1	13.65%	64
2	28.57%	134
3	20.26%	95
4+	33.48%	157
Not App cab e - No onger pract c ng	2.77%	13
TOTAL		469

Q3 Which of the following Oregon certifications does your dental assistant(s) hold? (Check all that apply)

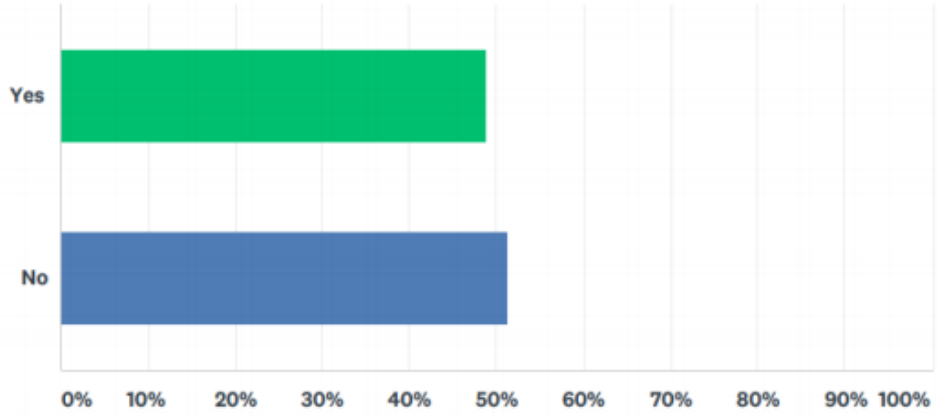
Answered: 461 Sk pped: 11



ANSWER CHOICES	RESPONSES	
Expanded Funct ons - Genera	84.16%	388
Expanded Funct ons - Genera w th Restorat ve Endorsement	8.46%	39
Expanded Funct ons - Orthodont c	19.09%	88
Expanded Funct ons - Prevent ve	13.02%	60
Anesthes a Ass stant	5.42%	25
None of the above	12.80%	59
Tota Respondents: 461		

Q4 Within your practice do you utilize the Dental Assisting National Board's (DANB) signoff sheet to train your dental assistant(s) to perform EFDA duties to obtain certification in Oregon?

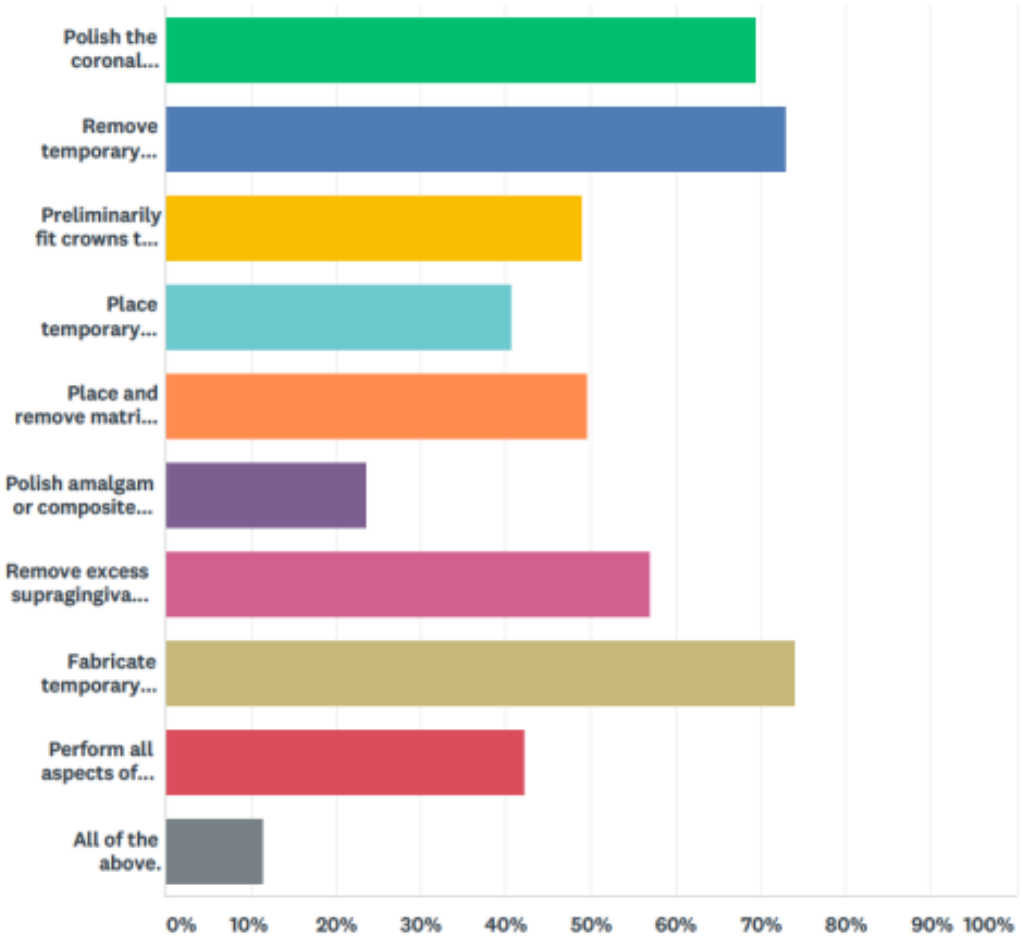
Answered: 462 Sk pped: 10



ANSWER CHOICES	RESPONSES	
Yes	48.70%	225
No	51.30%	237
TOTAL		462

Q5 Which expanded function duties do you allow your assistant(s) to perform once certified in Oregon? (Check all that apply)

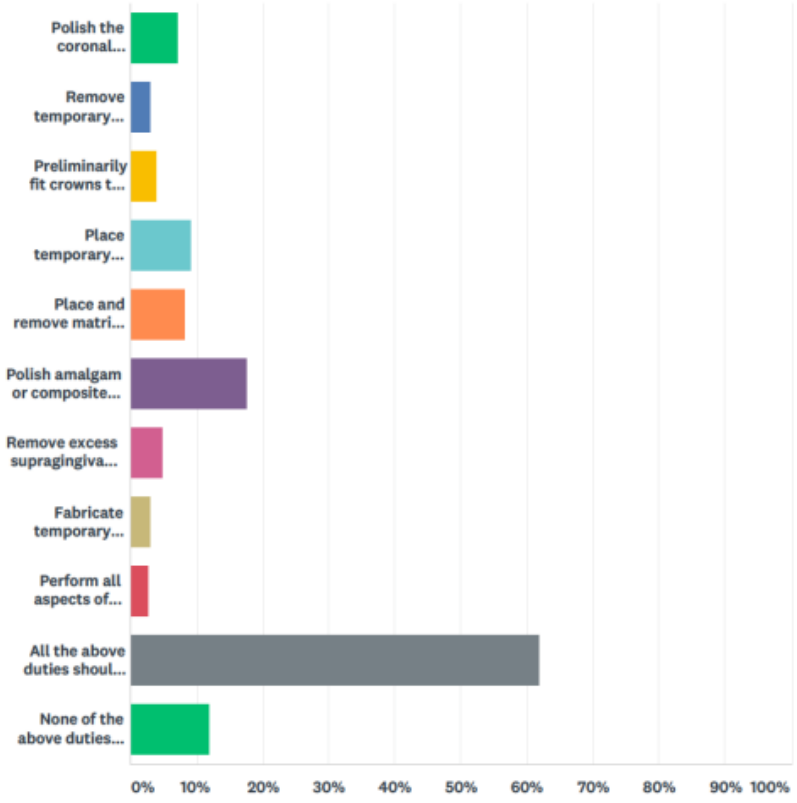
Answered: 409 Sk pped: 63



ANSWER CHOICES	RESPONSES	
Po sh the corona surfaces of teeth w th a brush or rubber cup as part of ora prophy ax s to remove sta ns.	69.44%	284
Remove temporary crowns for f na cementat on and c ean teeth for f na cementat on.	73.11%	299
Pre m nar y f t crowns to check contacts or to adjust occ us on outs de the mouth.	48.90%	200
P ace temporary restorat ve mater a (.e., z nc ox de eugeno based mater a).	40.59%	166
P ace and remove matr x reta ners for a oy and compos te restorat ons.	49.63%	203
Po sh ama gam or compos te surfaces w th a s ow speed hand p ece.	23.72%	97
Remove excess suprag ng va cement from crowns, br dges, bands or brackets w th hand nstrument.	56.97%	233
Fabr cate temporary crowns, and temporar y cement the temporary crown.	74.08%	303
Perform a aspects of teeth wh ten ng procedures.	42.30%	173
A of the above.	11.49%	47

Q6 Which EFDA duties, if any, do you consider obsolete? (Check all that apply)

Answered: 376 Sk pped: 96



ANSWER CHOICES	RESPONSES	
Po sh the corona surfaces of teeth w th a brush or rubber cup as part of ora prophy ax s to remove sta ns.	7.18%	27
Remove temporary crowns for f na cementat on and c ean teeth for f na cementat on.	2.93%	11
Pre m nar y f t crowns to check contacts or to adjust occ us on outs de the mouth.	3.99%	15
P ace temporary restorat ve mater a (.e., z nc ox de eugeno based mater a).	9.31%	35
P ace and remove matr x reta ners for a oy and compos te restorat ons.	8.24%	31
Po sh ama gam or compos te surfaces w th a s ow speed hand p ece.	17.55%	66
Remove excess suprag ng va cement from crowns, br dges, bands or brackets w th hand nstruments.	4.79%	18
Fabr cate temporary crowns, and temporar y cement the temporary crown.	2.93%	11
Perform a aspects of teeth wh ten ng procedures.	2.66%	10
A the above dut es shou d rema n as expanded funct on dut es.	61.97%	233
None of the above dut es shou d rema n expanded funct on dut es.	11.97%	45
Tota Respondents: 376		

Q7 What duties would you like to see added to the expanded functions list?

Answered: 181 Sk pped: 291

The majority of the answers showed that the dentists would like EFDA dental assistants to perform the following duties:

- Local Anesthesia
- Final Impressions
- Pack retraction cord (Already allowed)
- Soft relines (Already allowed)
- Start nitrous oxide
- Periodontal probing

The Oregon Dental Assistant Association (ODAA) met and would like the DAWSAC committee to know that our association supports some type of Registration for dental assistants. The purpose would be to help and have some means of communicating with assistants throughout the state. This would not mean another certificate but rather a way to connect for Rules updates, education, other work-related notices and information. This would also be helpful and ensure that the assistant would receive information personally, rather than something sent to the office and never received by the assistant, which as history might show, often happens.

The ODAA also supports the ODHA position regarding the prohibited duties listed in the Rules to help with clarification of those duties including scaling and probing, by only dental hygienists. Another recent topic being discussed is that of a POA. The ODAA also supports ODHA's position on this issue. There are many topics and concerns regarding this as a possible duty for a dental assistant which ODAA opposes. Thank you for taking our position when considering this in your discussions.

Mary Harrison CDA Emeritus, EFDA, EFODA, FADAA

Legislative Chair, ODAA

September 9, 2025

DAWSAC Members
Oregon Board of Dentistry
1500 SW First Street, Suite 770
Portland, OR 97201

The Oregon Board of Dentistry is considering a proposed rule change to **OAR 818-042-0040 Prohibited Acts** that would **clarify** that dental assistants are currently prohibited by law from performing scaling and periodontal probing. While this is already implied by an **existing law**, the proposed rule change aims to eliminate any ambiguity and reinforce patient safety standards.

This proposed rule change is **consistent with the law ORS 680.020** that states "It is unlawful for any person not otherwise authorized by law to practice dental hygiene or purport to be a dental hygienist without a valid license to practice dental hygiene issued by the Oregon Board of Dentistry."

The proposed rule change would add this underlined language to **OAR 818-042-0040**:

- **(12) Use hand instruments, air polishers, ultrasonic equipment or other devices to remove supragingival and subgingival stains and deposits from tooth surfaces.**
- (2~~2~~3) Perform periodontal assessment **and periodontal probing**.

We understand that there are dentists and dental team members who do not know that it is currently unlawful to practice dental hygiene or to present yourself as a dental hygienist without a valid dental hygiene license. This proposed rule change is intended to clarify that it is currently illegal for dental assistants to perform scaling and periodontal probing. This change will also help Board staff respond to questions they receive about this issue.

I plan to attend your next meeting on Tuesday, September 23 and so I will be available to discuss this issue with your committee.

Sincerely,

Lisa J. Rowley

Lisa J. Rowley, Advocacy Director
Oregon Dental Hygienists' Association
lisajrowley.rdh@outlook.com

Oregon Dental Assistant Employment and Pay History

Year	Total Employed	Hourly Mean	Annual Mean	Hourly 10th percentile wage	Hourly 25th percentile wage	Hourly median wage (50th percentile)	Hourly 75th percentile wage	Hourly 90th percentile wage	Annual 10th percentile wage	Annual 25th percentile wage	Annual median wage (50th percentile)	Annual 75th percentile wage	Annual 90th percentile wage
2024	5,480	27.74	57,690	23.16	25.52	27.75	28.75	34.18	48,160	53,090	57,720	59,800	71,090
2023	5,180	26.90	55,960	22.63	23.77	27.42	29.39	30.73	47,070	49,430	57,040	61,130	63,920
2022	5,200	25.00	51,990	20.01	22.98	24.09	27.73	29.51	41,610	47,800	50,110	57,680	61,380
2021	5,480	23.45	48,780	17.90	22.31	23.01	27.96	28.95	37,240	46,410	47,850	58,170	60,220
2020	4,550	23.23	48,320	17.80	20.66	23.19	25.87	29.70	37,030	42,970	48,240	53,800	61,780
2019	4,890	22.57	46,940	16.79	19.64	22.56	25.51	29.29	34,910	40,850	46,930	53,060	60,910
2018	5,040	20.89	43,440	15.15	17.74	21.15	23.91	26.93	31,500	36,900	43,990	49,730	56,010
2017	5,480	20.42	42,470	14.41	17.19	20.80	23.52	26.17	29,960	35,750	43,260	48,920	54,420
2016	5,270	20.26	42,130	14.04	17.02	20.56	23.34	26.63	29,210	35,400	42,760	48,550	55,390
2015	4,910	20.04	41,680	15.01	17.03	20.06	22.88	26.28	31,220	35,430	41,730	47,590	54,650
2010	4,750	18.15	37,750	13.68	15.91	17.94	20.46	22.93	28,450	33,100	37,330	42,560	47,690
2002	5260	14.61	30380	9.56	11.29	14.91	17.48	20.22	19,890	23,470	31,020	36,360	42,060

Information from the U.S. Bureau of Labor Statistics
https://www.bls.gov/oes/tables.htm

2024 Employment Numbers and Pay in Oregon

Area		Total Employed	Hourly Mean	Annual Mean
Albany, OR	Dental Assistants	120	26.14	54,380
Bend, OR	Dental Assistants	320	27.54	57,290
Corvallis, OR	Dental Assistants	100	25.69	53,440
Eugene-Springfield, OR	Dental Assistants	490	26.24	54,570
Grants Pass, OR	Dental Assistants	90	27.30	56,780
Medford, OR	Dental Assistants	290	25.74	53,530
Portland-Vancouver-Hillsboro, OR-WA	Dental Assistants	3,720	28.11	58,470
Salem, OR	Dental Assistants	560	27.07	56,310
Albany, OR	Dental Hygienists	80	54.58	113,520
Bend, OR	Dental Hygienists	240	55.96	116,400
Corvallis, OR	Dental Hygienists	70	52.26	108,690
Eugene-Springfield, OR	Dental Hygienists	310	51.40	106,910
Grants Pass, OR	Dental Hygienists	70	55.97	116,420
Medford, OR	Dental Hygienists	220	53.54	111,360
Portland-Vancouver-Hillsboro, OR-WA	Dental Hygienists	2,170	57.21	119,000
Salem, OR	Dental Hygienists	360	55.41	115,250

Information from the U.S. Bureau of Labor Statistics
https://www.bls.gov/oes/tables.htm

Dental Assistant Employment Trends in Oregon

Living Wage in Oregon

From MIT Living Wage Calculator

1 Adult	1 Adult and 1 Child
$25.16 (52,332.80 annually)	$45.17 ($93,953.60 annually)

Oregon Population 2015-2024		
Year	Population	Annual Growth Rate
2024	4,272,371	0.44%
2023	4,253,653	0.15%
2022	4,247,372	-0.16%
2021	4,254,280	0.25%
2020	4,243,779	0.66%
2019	4,216,116	0.78%
2018	4,183,538	0.87%
2017	4,147,294	1.32%
2016	4,093,271	1.86%
2015	4,018,542	1.34%

MacroTrends and the U.S. Census Bureau
https://www.macrotrends.net/global-metrics/states/oregon/population

Supply of Dentists in the U.S. by State 2001-2022

Oregon

Year	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022
Oregon	2,204	2,192	2,281	2,344	2,390	2,438	2,497	2,535	2,594	2,610	2,651	2,653	2,720	2,702	2,763	2,757	2,808	2,820	2,835	2,826	2,787	2,803

Source: American Dental Association, Health Policy Institute analysis of ADA masterfile.