

OREGON BOARD OF DENTISTRY
 UNIT 23
 PO BOX 4395
 PORTLAND, OR 97208-4395

**Application for Certification by Credential
 In Expanded Functions (General)
 \$50.00 (Non-Refundable)**

Name: _____

Address: _____

City: _____ State _____ Zip _____ Telephone _____

Employer: _____
 (If applicable)

Address: _____

City: _____ State _____ Zip _____ Telephone _____

INSTRUCTIONS

You can **ONLY** apply for Certification by Credential in Expanded Functions (General) if you hold a certificate from another state **or** you have worked as a dental assistant for at least 1,000 hours in a dental office within the last two (2) years, **outside** the state of Oregon, where such employment involved, to a significant extent, performing **all** Expanded Functions (General) listed on the Pathway 1 or Pathway 2 verification forms. You must mail the application (the first two pages of this document) and fee to the address on page one (1) of the application form. **If you have not been certified or have not performed, to a significant extent, all of the Expanded Functions (General) listed on these forms, within the last two (2) years, you do not qualify for Certification by Credentials.**

Pathway 1 (Certified in Another State):

Have the state in which you are currently certified submit directly to the Oregon Board of Dentistry the Verification of Certification Form (attached). Original forms must be submitted; faxes or copies are not acceptable. **This form must be submitted directly from the State, to the Oregon Board of Dentistry. Forms that are not mailed directly from the State will not be accepted.**

or

Pathway 2 (1,000 hours of Clinical Practice)

Verification of Hours: List all locations at which you practiced within the last two years, **outside of Oregon**, to verify the 1,000 hours of practice requirement. Use additional sheets if necessary.

Verification of Competence: Verification by a licensed dentist(s), **outside of Oregon**, that **you have worked at least 1,000 hours, within the last two (2) years, as a dental assistant for the dentist(s) where such employment involved to a significant extent your performing all expanded duties.** (Form attached, use additional sheets if necessary). **This form must be completed by the dentist(s) and mailed directly from the dentist(s) to the Oregon Board of Dentistry. Forms that are not mailed directly from the dentist(s) will not be accepted. Original forms must be mailed; faxes or copies are not acceptable.**

VERIFICATION

Pathway 1 Please list and submit copies of current licenses and/or certificates that apply:

Pathway 2 Verification of Hours: List all employers, outside of Oregon, where you have practiced at least 1,000 hours in a dental office **within the last two (2) years**, where such employment involved to a significant extent your performing **all** Expanded Functions (General). Use additional sheets if necessary.

Name of Dentist _____

Location/Address _____

Average hours per week _____

From _____ to _____ TOTAL _____ hours _____ years _____ months
(Date) (Date)

Name of Dentist _____

Location/Address _____

Average hours per week _____

From _____ to _____ TOTAL _____ hours _____ years _____ months
(Date) (Date)

Name of Dentist _____

Location/Address _____

Average hours per week _____

From _____ to _____ TOTAL _____ hours _____ years _____ months
(Date) (Date)

I certify this application is correct and that I am either certified in another state to perform the duties for which I'm applying or I have worked as a dental assistant for at least 1,000 hours in the past two years, **outside of Oregon**, where such employment involved to a significant extent my performing **all** Expanded Functions (General).

Assistant's Signature _____ Date _____

Verification of Certification

Name of Dental Assistant (Please Print or Type)		
Address		
City	State	Zip
License/Certificate No.		Date Issued

I certify that

was granted license/certificate number _____ to perform the following expanded functions in the State of _____ on the basis of successfully passing the following examination(s):

Examination:

Clinical examination Yes No
 Written examination Yes No

Expanded Functions:

- | | | |
|--------------------------|--------------------------|---|
| Yes | No | |
| <input type="checkbox"/> | <input type="checkbox"/> | Polish the coronal surfaces of teeth with a brush or rubber cup as part of oral prophylaxis to remove stains; |
| <input type="checkbox"/> | <input type="checkbox"/> | Remove temporary crowns for final cementation and clean teeth for final cementation; |
| <input type="checkbox"/> | <input type="checkbox"/> | Preliminarily fit crowns to check contacts or to adjust occlusion outside the mouth; |
| <input type="checkbox"/> | <input type="checkbox"/> | Place temporary restorative material; |
| <input type="checkbox"/> | <input type="checkbox"/> | Place and remove matrix retainers for alloy and composite restorations; |
| <input type="checkbox"/> | <input type="checkbox"/> | Polish amalgam or composite surfaces with a slow speed handpiece; |
| <input type="checkbox"/> | <input type="checkbox"/> | Remove excess supragingival cement from crowns, bridges, bands or brackets with hand instruments; |
| <input type="checkbox"/> | <input type="checkbox"/> | Fabricate temporary crowns, and temporarily cement the temporary crown; and |
| <input type="checkbox"/> | <input type="checkbox"/> | Perform all aspects of teeth whitening procedures. |

 Secretary

 (Date Certificate Prepared)

SEAL

Return to: Oregon Board of Dentistry
 1500 SW 1st Avenue, Suite 770
 Portland, Oregon 97201

**VERIFICATION OF COMPETENCE
IN EXPANDED FUNCTIONS (GENERAL)**

Licensed Dentist (Outside of Oregon)

Name of Dentist _____

Address _____

City _____ State _____ Zip _____ Telephone _____

I hereby certify that _____
(Assistant's Name)

Has worked at least _____ hours **for me** in the last two years and is competent to perform the following expanded functions, and has performed within the last two years to a significant extent **all** of the expanded functions:

Expanded Functions:

- | Yes | No | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Polish the coronal surfaces of teeth with a brush or rubber cup as part of oral prophylaxis to remove stains; |
| <input type="checkbox"/> | <input type="checkbox"/> | Remove temporary crowns for final cementation and clean teeth for final cementation; |
| <input type="checkbox"/> | <input type="checkbox"/> | Preliminarily fit crowns to check contacts or to adjust occlusion outside the mouth; |
| <input type="checkbox"/> | <input type="checkbox"/> | Place temporary restorative material; |
| <input type="checkbox"/> | <input type="checkbox"/> | Place and remove matrix retainers for alloy and composite restorations; |
| <input type="checkbox"/> | <input type="checkbox"/> | Polish amalgam or composite surfaces with a slow speed handpiece; |
| <input type="checkbox"/> | <input type="checkbox"/> | Remove excess supragingival cement from crowns, bridges, bands or brackets with hand instruments; |
| <input type="checkbox"/> | <input type="checkbox"/> | Fabricate temporary crowns, and temporarily cement the temporary crown; and |
| <input type="checkbox"/> | <input type="checkbox"/> | Perform all aspects of teeth whitening procedures. |

Dentist's Signature _____ Date _____

License Number _____ State _____

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