South Dakota State Board of Dentistry

P.O. Box 1079, 1351 N. Harrison Ave. Pierre, SD 57501-1079

Ph: 605-224-1282 Fax: 1-888-425-3032

E-mail: contactus@sdboardofdentistry.com www.sdboardofdentistry.org

REGISTERED DENTAL ASSISTANT APPLICATION

The following items must be submitted with your application. Application documents will not be returned to you.

- ☐ Completed application;
- ☐ Non-refundable application fee of $45 (check or money orders only, do not send cash);
- ☐ A copy of your birth certificate or government-issued identification *(applicant must be at least 18 years old)*;
- ☐ A copy of your current Board approved cardiopulmonary resuscitation (CPR) card. A Board approved CPR course is a course intended for a Healthcare Provider that meets the required knowledge and objectives outlined in the American Heart Association guidelines for BLS or American Heart Association Guidelines for CPR and ECC, and includes a hands-on skills assessment;
- ☐ Proof of one of the following:
  - Graduation from a CODA accredited dental assisting program. Graduates of Western Dakota Technical College (WDTC) or Southeast Technical College (STC) prior to October 2020 should contact the Board office to verify approval status.
  - Verification that you are a Certified Dental Assistant through the Dental Assisting National Board (DANB); or
  - Verification of successful completion of the Expanded Functions Dental Assistant (EFDA)- Verification of Skills course at Lake Area Technical College.
- ☐ If applicable, documentation of any name change (i.e. marriage license);
- ☐ If applicable, a verification letter from each state in which you are or have been registered.

If you are an active duty member of the armed forces of the United States or the spouse of an active duty member of the armed forces of the United States who is the subject to a military transfer to South Dakota and hold a license or registration in good standing to practice as a Registered Dental Assistant in another state, please contact our office for an Active Duty Military Personnel or Spouse License or Registration Application.

Name (First, Middle, Last): _____

Home Address: _____

City: _____ State: _____ Zip: _____

Phone:_____ Date of Birth: _____Social Security Number: _____

Email: _____

This email will be used to correspond with you regarding your application. Please be sure the email is current.

Office Name: _____

Office Address: _____Office Phone: _____

City: _____ State: _____ Zip: _____

If you have more than one office location, please include that information at the end of this application..

Radiography permits must be applied for separately. Applications are available at www.sdboardofdentistry.org.

I am currently registered as a Radiographer in South Dakota. ☐ **Yes** ☐ **No**

If yes, my registration number is: _____

Please answer the following:

1. Have you ever had disciplinary action taken against your registration in any state for any reason? ☐ Yes ☐ No

If yes, please provide a detailed explanation in the space provided at the end of this application.

2. Have you ever been convicted, pled no contest/nolo contendere, pled guilty to, or been granted a deferred judgment or suspended imposition of sentence or had prosecution deferred with respect to a felony? ☐ Yes ☐ No

If yes, please provide a detailed explanation in the space provided at the end of this application.

3. Have you ever been convicted, pled no contest/nolo contendere, pled guilty to, or been granted a deferred judgment or suspended imposition of sentence or had prosecution deferred with respect to a criminal offense arising out of the practice of dentistry? ☐ Yes ☐ No

If yes, please provide a detailed explanation in the space provided at the end of this application.

4. Are you or your spouse an active duty member of the armed forces of the United States? ☐ Yes ☐ No

5. If yes, were you or your spouse the subject of a military transfer to South Dakota? ☐ Yes ☐ No

6. Do you currently hold a valid registration issued by a different state or the District of Columbia to practice as a registered dental assistant? ☐ Yes ☐ No

7. Please complete the following information for each state in which you are or have been registered.

STATE_____REGISTRATION #_____DATE RECEIVED_____STATUS_____
STATE_____REGISTRATION #_____DATE RECEIVED_____STATUS_____

You must also submit a certified letter verifying the registration number and status of your registration from the board of dentistry in each state in which you are or have been registered if that state does not provide online verification. These letters must be sent directly to our office.

8. Have you been out of practice for any length of time? ☐ Yes ☐ No

If yes, what dates were you not practicing?

From _____ (month/year) to _____ (month/year)

From _____ (month/year) to _____ (month/year)

If you have been out of practice for the five years preceding application, you will be required to verify competency.

9. By initialing below, I hereby attest that the CPR course I am submitting a card for meets all of the following requirements:
   _____ Is a Basic Life Support course intended for a Healthcare Provider; and
   _____ Included knowledge and objectives in accordance with the American Heart Association Guidelines for BLS or American Heart Association Guidelines for CPR and ECC; and
   _____ Included a hands-on skill assessment.

I declare and affirm under the penalties of perjury that this application has been examined by me and to the best of my knowledge and belief is in all things true and correct.

Signature: _____ Date: _____

Printed Name: _____

Mail completed application, required documentation and $45.00 application fee to:
South Dakota State Board of Dentistry
PO Box 1079
Pierre, SD 57501

For Office Use Only:
Check # _____
Amount _____
Date _____

Satellite office locations, if applicable:

Office Name: _____

Office Address: _____ Office Phone: _____

City: _____ State: _____ Zip: _____

Office Name: _____

Office Address: _____ Office Phone: _____

City: _____ State: _____ Zip: _____

Office Name: _____

Office Address: _____ Office Phone: _____

City: _____ State: _____ Zip: _____

If you have answered Yes to Questions 1, 2 and/or 3 on page 2 of the application, please provide your explanation below. For each disciplinary action or criminal offense, you must list the action/offense and a detailed explanation of the action/offense. If you have more than one action or offense to disclose, you must list them in chronological order (most recent first). You must also submit copies of all communications (to and from) the citing agency or board, including evidence of completion/compliance with requirements. You must group the documents by violation and put them in chronological order (most recent first).