South Dakota State Board of Dentistry
P.O. Box 1079, 1351 N. Harrison Ave. Pierre, SD 57501-1079
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E-mail: contactus@sdboardofdentistry.com www.sdboardofdentistry.com

REGISTERED DENTAL ASSISTANT APPLICATION

Submit the following:

1. Completed application;
2. Fee of $40 (check or money orders only, do not send cash);
3. A copy of your birth certificate *(applicant must be at least 18 years old)*;
4. A copy of your current cardiopulmonary resuscitation (CPR) card. The Board accepts only the American Heart Association for the Basic Life Support Provider (BLS) or the American Red Cross for Basic Life Support (BLS);
5. Proof of one of the following:
   a. Graduation from a CODA accredited dental assisting program. Note, Western Dakota Technical Institute (WDTI) has approval pending CODA accreditation. Southeast Technical College (STC) has approval pending CODA accreditation for graduates between 10/23/2020 and 10/31/2022.
   b. Verification that you are a Certified Dental Assistant through the Dental Assisting National Board (DANB); or
   c. Verification of successful completion of the Expanded Functions Dental Assistant course at Lake Area Technical Institute (approximately 60 hours on-line/40 hours hands on instruction)
6. If applicable, documentation of any name change (i.e. marriage license);
7. 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: _____ 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: _____

Satellite Office Name: _____

Satellite Office Address: _____ Satellite Office Phone: _____

City: _____ State: _____ Zip: _____

If you have more than one satellite office, please include that information on another page.

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

If yes, my registration number is: _____

Version 21.11.24

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 or 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.

3. 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

4. Are you an active duty member or the spouse of 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. Have you been out of the 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)

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.

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

STATE_____REGISTRATION #_____DATE RECEIVED_____STATUS_____

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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: _____

For Office Use Only: Check # _____Amount _____ Date _____

If you have answered Yes to Questions 1 and/or 2, 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).