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.com

DENTAL RADIOGRAPHER APPLICATION

Pursuant to ARSD § 20:43:07 you must submit the following:

1. Completed application;
2. Fee of $40 (check or money orders only, do not send cash);
3. A copy of your government-issued identification;
4. Verification of one of the following:
    a. Completion of a 16 hour Board approved program or course of study within thirteen months of application, which include the following:
        i. 16 hour Radiography courses taken through an ADA CODA accredited dental, dental hygiene or dental assisting program;
        ii. 16 hour Radiography courses taken through Western Dakota Technical Institute (WDTI);
        iii. 16 hour Radiography courses taken through Southeast Technical Institute (SETI);
        iv. 16 hour Radiography courses taken through Accelerated Dental Assisting Academy (ADAA) with a completion date after October 18, 2019;
        v. Radiography component of Dental Assisting National Board (DANB);
    b. Verification that you are a Certified Dental Assistant through the Dental Assisting National Board (DANB); or
    c. Completion of a 16 hour Radiography course taken more than thirteen months ago that included training in the areas outlined in § 20:43:07:06, verification of clinical competency (*see page 4 of this application*), and verification that you are or have been legally practicing as a dental radiographer in a different state.
5. If applicable, documentation of any name change (i.e. marriage license);
6. 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 Radiography 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.

I am currently registered as a Registered Dental Assistant in South Dakota. ☐ **Yes** ☐ **No**

If yes, my registration number is: _____

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.

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 radiographer? ☐ **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)

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. These letters must be sent directly to our office.*

STATE_____REGISTRATION #_____DATE RECEIVED_____STATUS_____

STATE_____REGISTRATION #_____DATE RECEIVED_____STATUS_____

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).

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This form is to be submitted with the *Dental Radiographer Application* only if the applicant completed a board approved course in dental radiography more than thirteen months prior to application and was authorized to provide this service in a state other than South Dakota during the three years preceding application.

To Whom It May Concern:

The South Dakota State Board of Dentistry is conducting a review of an applicant for a permit to practice radiography in the State of South Dakota. One of the requirements for that permit is written documentation from a dentist that has employed or supervised the applicant, attesting to the current clinical proficiency of the applicant to practice radiography. Please provide your professional assessment of the applicant's current clinical proficiency to practice radiography by completing the form below.

Applicant's Name: _____

Date of Completion: _____

I supervised or employed the above named applicant during the following timeframe _____/_____ (month/year) through _____/_____ (month/year). During that timeframe, he/she legally practiced radiography in the state of - _____. I hereby certify the above named applicant is ***currently*** clinically proficient to practice radiography.

_____ _____
Name of Office Address

_____ (_____)_____
City, State, Zip Office Phone Number

_____ _____ _____
Dentist Name (Print) Dentist License # State

_____ _____
Signature of Dentist Date

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