



## 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](mailto:contactus@sdboardofdentistry.com)

[www.sdboardofdentistry.org](http://www.sdboardofdentistry.org)

### DENTAL RADIOGRAPHER 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;

If applicable, documentation of any name change (i.e. marriage license);

Verification of one of the following:

- Completion of a 16 hour Radiography course taken through an ADA CODA accredited dental, dental hygiene or dental assisting program within thirteen months of application;
- Completion of the DA Prep Dental Radiography course taken after October 18, 2024 *and* within thirteen months of application;
- Completion of the Radiography component of Dental Assisting National Board (DANB) within thirteen months of application;
- Verification that you are a Certified Dental Assistant through the Dental Assisting National Board (DANB); or
- Completion of an approved 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.

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: \_\_\_\_\_ 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 Phone: \_\_\_\_\_

Office Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

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

I am currently registered as a Registered Dental Assistant 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 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. Do you currently hold a valid registration issued by a different state or the District of Columbia to practice as a radiographer? **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 _____
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)*

*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 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).



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### **Dental Radiographer Application – Verification of Clinical Proficiency**

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 be completed by the applicant:**

Applicant's Name: \_\_\_\_\_

Date of Completion of Board approved Radiography course: \_\_\_\_\_

State, other than South Dakota, in which you practiced Radiography: \_\_\_\_\_

License/ Registration # for that state: \_\_\_\_\_

Signature of Applicant: \_\_\_\_\_ Date: \_\_\_\_\_

#### **To be completed by the supervising dentist:**

The applicant named above is applying for a permit to practice radiography in the State of South Dakota. Written documentation from a dentist that has employed or supervised the applicant, attesting to the current clinical proficiency of the applicant to practice radiography, is required. Please provide your professional assessment of the applicant's current clinical proficiency to practice radiography by completing below.

Supervising Dentist Name: \_\_\_\_\_ License #: \_\_\_\_\_

Office Name: \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_ Phone: \_\_\_\_\_

During the previous three years, I supervised or employed the above named applicant from: \_\_\_\_/\_\_\_\_ (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.

\_\_\_\_\_  
Dentist Signature

\_\_\_\_\_  
Date