# OHIO STATE DENTAL BOARD

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## PERMISSIBLE PRACTICES DOCUMENTATION FOR DENTAL ASSISTANTS

**THIS FORM AND COPIES OF ALL SUPPORTING DOCUMENTATION ATTACHED MUST BE MAINTAINED IN THE DENTAL OFFICE WHERE THE DENTAL ASSISTANT IS PRACTICING THE FOLLOWING DUTIES AND OR PROCEDURES:**

**Basic Qualified Personnel**

- ☐ Monitoring of nitrous oxide-oxygen ($N_2O$-$O_2$) minimal sedation
- ☐ Dental Assistant Radiographer Certificate

**Certified Dental Assistant**

- ☐ Pit and fissure sealants
- ☐ Coronal Polishing Certificate
- ☐ Practice when the dentist is not physically present

**ALL SECTIONS OF THIS DOCUMENT MUST BE COMPLETED INDICATING THE DUTIES AND/OR FUNCTIONS YOU HAVE BEEN APPROPRIATELY TRAINED/EDUCATED TO PROVIDE. IF YOU DO NOT MEET THE SPECIFIC REQUIREMENTS TO PERFORM THESE DUTIES/FUNCTIONS, CHECK THE APPROPRIATE BOX IN THAT SECTION.**

### SECTION 1 CERTIFICATE/REGISTRATION HOLDER INFORMATION

Name: _____ Radiographer Cert. #: _____

Other Names Used: _____ Coronal Polishing Cert. #: _____

_____ EFDA Registration #: _____

### SECTION 2 SUPERVISING DENTIST INFORMATION

Name: _____ Ohio License #: _____

Name of Practice: _____

Address: _____

_____

City: _____ State: _____ Zip Code: _____

**Definition:** As supervising dentist, I have evaluated the above-named dental assistant's skills and I have made a determination that this dental assistant has received the appropriate training and/or examination requirements for all permissible duties indicated on this form and is competent to perform them. I further attest that the information contained herein is true and accurate to the best of my knowledge and belief:

Name (print): _____ Date: _____

Signature: _____

## SECTION 3 — MONITORING OF NITROUS OXIDE-OXYGEN ($N_2O$-$O_2$) MINIMAL SEDATION

In order to be allowed to perform this function, you MUST be currently certified to perform basic life support through the AHA, ARC, or ASHI. A copy of current AHA, ARC, or ASHI CPR Certification **and** a copy of your certificate of completion of a course meeting the requirements for monitoring of $N_2O$-$O_2$ minimal sedation must be attached.

☐ I do not meet the educational/training requirements to perform this function.

☐ I have completed a six-hour course in nitrous oxide-oxygen ($N_2O$-$O_2$) minimal sedation monitoring and I have successfully passed the written examination provided by a **Permanent Sponsor** which met the curriculum requirements set forth in Ohio Administrative Code section 4715-11-02.1 (attach a copy of the certificate of completion for the course and the examination).

**OR**

☐ I have graduated on or after January 1, 2010 from an ADA CODA accredited program and have completed the equivalent training within the curriculum as set forth in Ohio Administrative Code section 4715-11-02.1(B)(2) (attach a copy of the curriculum indicating compliance with the requirements).

**OR**

☐ I hold a current dental auxiliary license, certificate, permit, registration, or other credential issued by another state for the monitoring of $N_2O$-$O_2$ minimal sedation and the training received was substantially equivalent to the required hours, content and examination requirements set forth in Ohio Administrative Code section 4715-11-02.1(B)(1) (attach a copy of the license/certificate/permit/registration or other credential from another state along with a copy of the specific education and examination requirements).

### NITROUS OXIDE-OXYGEN ($N_2O$-$O_2$) MINIMAL SEDATION MONITORING COURSE

Name of Permanent Sponsor: Location (City, State): Date of Completion:

Course Title: _____

### ADA CODA ACCREDITED PROGRAM

Name of ADA CODA Accredited Program: Location (City, State): Date of Completion:

### STATE CERTIFICATE/REGISTRATION/PERMIT

List the state in which you hold a certificate, permit, registration or other credential allowing you to monitor $N_2O$-$O_2$ minimal sedation.

State: License #: Date Issued: Date Expired:

Basic Qualified Personnel must have at least two years of active practice and at least 3,000 hours of experience in the practice of dental assisting in order to be allowed to perform this function.

### EMPLOYMENT HISTORY FOR SECTION 3

List all places/dates of employment to demonstrate that you have a minimum of two years of active practice and at least 3,000 hours of experience in the practice of dental assisting. You may make copies of this section if additional employment is required to document sufficient experience.

Name: _____ Phone #: _____

Name of Practice: _____ Dates Practiced: _____

Address: _____ Total Hours: _____

City: _____ State: _____ Zip Code: _____

Name: _____ Phone #: _____

Name of Practice: _____ Dates Practiced: _____

Address: _____ Total Hours: _____

City: State: Zip Code:

## SECTION 4 DENTAL ASSISTANT RADIOGRAPHER CERTIFICATE

In order to be allowed to perform this function, you MUST have received a Dental Assistant Radiographer's certificate from the Board. A copy of your Board-issued Dental Assistant Radiographer Certificate **and/or** a copy of your current renewal receipt card must be attached.

☐ I do not meet the educational/training/Board certification requirements to perform this function.

☐ I have completed a seven-hour board-approved dental assistant radiographer initial training course, including the clinical requirements, through an accredited educational institution or program or a permanent sponsor of the Board (see Ohio Administrative Code 4715-12-04 (A) and (B));

**OR**

☐ I am a currently Certified Dental Assistant (CDA) through the Dental Assisting National Board (DANB) or a current Certified Ohio Dental Assistant (CODA) through the Ohio Commission on Dental Assistant Certification (OCDAC) (see Ohio Administrative Code 4715-12-02 (B)(1));

**OR**

☐ I hold a current license, certificate, or other credential issued by another state that the board determines uses standards for dental assistant radiographers that are at least equal to those established by State Dental Board rules (see Ohio Administrative Code 4715-12-02 (B)(2));.

## SECTION 5 PIT AND FISSURE SEALANTS

In order to be allowed to perform this function, you MUST be a currently Certified Dental Assistant (CDA) through the Dental Assisting National Board (DANB) or a currently Certified Ohio Dental Assistant (CODA) through the Ohio Commission on Dental Assistant Certification (OCDAC). A copy of your current DANB or OCDAC Certification **and** a copy of your certificate of completion of a course meeting the requirements for pit and fissure sealants must be attached.

☐ I do not meet the educational/training requirements to perform this function.

☐ I have completed an eight-hour course in the application of sealants consisting of at least two hours of didactic instruction and six hours of clinical instruction through an ADA CODA accredited educational institution or a program provided by a Board approved or accepted sponsor of continuing education (see Ohio Administrative Code 4715-11-03 (B)(1)).

### COURSE

Name of ADA CODA Accredited Institution or Sponsor: Location (City, State): Date of Completion:

Course Title:

## SECTION 6 CORONAL POLISHING CERTIFICATE

In order to be allowed to perform this function, you MUST be a currently Certified Dental Assistant (CDA) through the Dental Assisting National Board (DANB) or a currently Certified Ohio Dental Assistant (CODA) through the Ohio Commission on Dental Assistant Certification (OCDAC) **AND** you **MUST** have received a Coronal Polishing certificate from the Board. A copy of your current DANB or OCDAC Certification **and** Board Coronal Polishing certificate must be attached.

☐ I do not meet the educational/training/Board certification requirements to perform this function.

☐ I have completed a seven-hour board-approved coronal polishing course (3 didactic and 4 clinical hours), including the clinical evaluation component, through an ADA CODA accredited educational institution or a college or university accredited by the Higher Learning Commission of the North Central Association of Colleges and Schools **and** I have successfully passed the standardized testing provided by the Dental Assisting National Board, the Ohio Commission on Dental Assistant Certification, or the educational institution wherein I successfully completed my approved training. (see Ohio Revised Code 4715.39 (B) and Ohio Administrative Code 4715-11-03.1 (B) and (C));

**OR**

☐ I am a currently Certified Dental Assistant (CDA) through the Dental Assisting National Board (DANB) or a current Certified Ohio Dental Assistant (CODA) through the Ohio Commission on Dental Assistant Certification (OCDAC) **and** I hold a current license, certificate, or other credential issued by another state that the board determines uses standards that are at least equal to those established by State Dental Board rules (see Ohio Administrative Code 4715-11-03.1).

## SECTION 7 PRACTICE WHEN THE DENTIST IS NOT PHYSICALLY PRESENT [CDA OR CODA ONLY]

In order to be allowed to perform this function, you MUST be a currently Certified Dental Assistant (CDA) through the Dental Assisting National Board (DANB) or a currently Certified Ohio Dental Assistant (CODA) through the Ohio Commission on Dental Assistant Certification (OCDAC) **AND** you MUST have completed a four hour Board-approved course meeting the requirements for identification and prevention of potential medical emergencies. Copies of your current DANB or OCDAC Certification **AND** a copy of your certificate of completion of a course meeting the requirements for identification and prevention of potential medical emergencies must be attached.

☐ I do not meet the educational/training requirements to perform this function.

☐ I have documented two years **and** 3,000 hours of experience in the practice of dental assisting **and** I have successfully completed a four-hour board-approved course in the identification and prevention of potential medical emergencies through a Permanent Sponsor, subsequent to completion of my dental assisting practice experience (copy of certificate of completion attached).

### COURSE

Name of **Permanent** Sponsor: Location (City, State): Date of Completion:

Course Title: _____

### EMPLOYMENT HISTORY

Certified assistants must have at least two years of active practice and at least 3,000 hours of experience in the practice of dental assisting in order to be allowed to perform this function. You may make copies of this section if additional employment is required to document sufficient experience.

Name: _____ Phone #: _____

Name of Practice: _____ Dates Practiced: _____

Address: _____ Total Hours: _____

City: _____ State: _____ Zip Code: _____

Name: _____ Phone #: _____

Name of Practice: _____ Dates Practiced: _____

Address: _____ Total Hours: _____

City: _____ State: _____ Zip Code: _____

Name: _____ Phone #: _____

Name of Practice: _____ Dates Practiced: _____

Address: _____ Total Hours: _____

City: _____ State: _____ Zip Code: _____

Name: _____ Phone #: _____

Name of Practice: _____ Dates Practiced: _____

Address: _____ Total Hours: _____

City: State: Zip Code:

## SECTION 8 — CARDIOPULMONARY RESUSCITATION (CPR) CERTIFICATE

I certify that I have completed and am current in a cardiopulmonary resuscitation (CPR) course provided by the American Heart Association, American Red Cross, or the American Safety and Health Institute pursuant to Ohio Revised Code 4715.62 and/or Ohio Administrative Code sections 4715-11-02.1, 4715-11-02.2, and 4715-11-04.1 when performing the following:

- Monitoring of nitrous oxide-oxygen ($N_2O$-$O_2$) minimal sedation; and/or
- Expanded Function Dental Auxiliary (EFDA) duties.

Signature: _____ Date: _____

## SECTION 9 — HEPATITIS B IMMUNIZATION/INOCULATION

I certify that I have immunity to or immunization against the hepatitis B virus. Attach one or both of the following supporting documentation:

- Medical documentation reflecting dates of the hepatitis B series acceptable to the Board; and/or
- Surface antibody blood titer with results indicating positive, reactive or levels greater than 9.9.

Signature: _____ Date: _____

## SECTION 10 — ATTESTATION

I have read the information in this form and have indicated truthfully, fully and completely those duties which I have been appropriately trained to provide in my scope of practice as a dental assistant. I further certify that I have read carefully and understand the law and rules pertaining to the practice of dental assisting, specifically regarding the aforementioned permissible duties and the education, training, examination and documentation requirements. I fully understand that falsification of any documentation may result in formal action by the Ohio State Dental Board.

Signature: _____ Date: _____

# ATTENTION

**THIS FORM (PAGES 1-5), ALONG WITH COPIES OF ALL SUPPORTING DOCUMENTATION ATTACHED, SHALL BE MAINTAINED IN ALL FACILITY(S) WHERE THE DENTAL ASSISTANT IS WORKING AND BE MADE AVAILABLE IMMEDIATELY UPON REQUEST.**

**DOCUMENTATION OF COMPLETION OF COURSES AND SUCCESSFUL EXAMINATION RESULTS ARE YOUR PERMANENT RECORD. WITH THE EXCEPTION OF BOARD-ISSUED DENTAL ASSISTANT RADIOGRAPHER AND CORONAL POLISHING CERTIFICATES, THE OHIO STATE DENTAL BOARD DOES NOT RECEIVE NOR RETAIN COPIES OF YOUR DOCUMENTATION.**